

Insights from the Top: An Oral History of Medicare and Medicaid



PHOTO: Former HCFA/CMS Administrators (standing, L-R): Bruce Vladeck, Mark McClellan, MD, Gail Wilensky, Leonard Schaeffer, Nancy-Ann Min DeParle, Donald Berwick, MD; (seated, L-R) William Roper, MD, Marilyn Tavenner, Thomas Scully. Photo made possible by Leonard Schaeffer.

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Insights from the Top: An Oral History of Medicare and Medicaid

Insights from the Top: An Oral History of Medicare and Medicaid was launched as part of the Academy's *Medicare and Medicaid at 50 and Beyond* celebration in 2015. The project was designed to uncover the rich history of the programs through the eyes of its leaders. It adds 23 new interviews to the existing CMS collection. These new interviews, as well as the earlier ones, were conducted by Edward Berkowitz, Professor of History at the George Washington University.

The Academy's 50th anniversary oral history project includes:

- First-time interviews with the four former Administrators who have served since 2001;
- First-time interviews with 14 former Acting or Acting Deputy Administrators; and
- Re-interviews of five former Administrators who served prior to 2001.

There are two ways to read these oral histories:

- By date of public service.
- Alphabetically by last name.

When reading the oral histories, keep in mind that each is the memory of a single individual. Read in context with other sources of information, they can add color and context, unavailable elsewhere, to important events. However, the full picture can only be seen when the perspectives of many individuals are combined into a meaningful whole.

Disclaimer: The opinions expressed in the interviews are those of the interviewee and do not reflect the views of the National Academy of Social Insurance, the Centers for Medicare & Medicaid Services, or the Department of Health and Human Services. Interviews are made public with the express consent of the interviewees.

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HCFA / CMS Leaders (by date of service, 1977-2014)

Name	HCFA/CMS Tenure	Title	Page No.
Donald Wortman	03/1977 – 04/1977	Acting	n/a
Robert Derzon*	06/1977 – 11/1978	Administrator	n/a
Leonard Schaeffer*	11/1978 – 06/1980	Administrator	270
Earl Collier	06/1980 – 07/1980	Acting	38
Howard Newman*	07/1980 – 01/1981	Administrator	n/a
Paul Willging	01/1981 – 03/1981	Acting Deputy	n/a
Carolyne Davis	03/1981 – 08/1985	Administrator	n/a
C. McClain Haddow	08/1985 – 01/1986	Acting	105
Henry Desmarais	02/1986 – 05/1986	Acting	69
William Roper	05/1986 – 02/1989	Administrator	258
Terry Coleman	02/1989 – 03/1989	Acting	n/a
Louis Hays	03/1989 – 02/1990	Acting	150
Gail Wilensky*	02/1990 – 03/1992	Administrator	414
J. Michael Hudson	03/1992 – 04/1992	Acting	163
William Toby	04/1992 – 05/1993	Acting	358
Bruce Vladeck*	05/1993 – 09/1997	Administrator	381
Nancy-Ann Min DeParle*	09/1997 – 09/2000	Acting Administrator, Administrator	54
Michael Hash*	09/2000 – 12/2000	Acting	130
Robert Berenson*	12/2000 – 01/2001	Acting Deputy	3
Michael McMullan*	01/2001 – 05/2001	Acting Deputy	221
Thomas Scully*	05/2001 – 12/2003	Administrator	299
Dennis Smith	12/2003 – 03/2004	Acting	324
Mark McClellan*	03/2004 – 10/2006	Administrator	204
Leslie Norwalk	10/2006 – 07/2007	Acting	235
Herb Kuhn	07/2007 – 09/2007	Acting Deputy	184
Kerry Weems	09/2007 – 01/2009	Acting	398
Charlene Frizzera	01/2009 – 10/2010	Acting	86
Donald Berwick*	07/2010 – 12/2011	Administrator	18
Marilyn Tavenner*	12/2011 – 02/2015	Administrator	344

* Elected to the National Academy of Social Insurance

n/a = not interviewed.

Interviews with HCFA / CMS Leaders (alphabetical by last name)

Robert Berenson, M.D.	3
Donald Berwick	18
Earl (Duke) Collier, Jr.	38
Nancy-Ann Min DeParle	54
Henry Desmarais, M.D.	69
Charlene Frizzera	86
C. McClain (Mac) Haddow.....	105
Michael Hash.....	130
Louis Hays	150
J. Michael Hudson.....	163
Herbert B. Kuhn.....	184
Mark McClellan.....	204
Michael McMullan.....	221
Leslie Norwalk	235
William Roper	258
Leonard D. Schaeffer	270
Thomas Scully.....	299
Dennis Smith	324
Marilyn Tavenner.....	344
William Toby.....	358
Bruce Vladeck	381
Kerry Weems.....	398
Gail Wilensky.....	414

Berkowitz:

Today is May 20, 2015, and we are at the headquarters of the National Academy of Social Insurance talking with Robert Berenson. Let's start with your background, if we might. Where did you grow up?

Berenson:

Elizabeth, New Jersey.

Berkowitz:

Home of the Singer sewing machine?

Berenson:

You've got it! Absolutely. Singer sewing machine. We had a good view of Bayway which was the home of Standard Oil of New Jersey. Elizabeth was known for having the highest cancer rates in the country with all the chemicals that were there, but it was a good place to grow up.

Berkowitz:

You also had, as I recall, nice sections, too. There were fancy sections of Elizabeth.

Berenson:

That's right. There were some nice sections.

Berkowitz:

You went to Brandeis for college, right? When was that?

Berenson:

In the height of the anti-war activities, '64 to '68. We were the first campus that was on the national news for burning draft cards back in about '67. It was an interesting time to be in college.

Berkowitz:

So, you were at Brandeis at the high days of Abram Sachar?

Berenson:

He actually retired our graduation year. In fact, I was the editor of the yearbook, and we were debating how to acknowledge him. He, at the time, was not very popular – had an “edifice complex,” which was not popular with students in the late '60s during the Vietnam War and with riots in US cities. He did one of the more amazing things I have witnessed. I

was interviewing him for the campus newspaper—earlier that day two graduate students had crashed an airplane on campus and died. He’s in the middle of answering my question, and he gets an intercom saying that the parents of one of the students are on the phone. He stops his conversation, does three to five minutes of heartfelt interaction with the family, turns to me, and immediately picks up in mid-sentence without even acknowledging the interruption -- it was, “whoa!”

Berkowitz:

So, then you went on to medical school after that. Was that kind of the plan?

Berenson:

It was the plan. My father was a surgeon. My older brother was a psychiatrist. During sophomore and junior year when Detroit, and Newark, and other places were on fire, I was thinking, well maybe I don’t want to just be a doctor. But my father said, “Become a doctor, and then you can do whatever you want to do.” And that’s actually how it’s turned out. I did practice medicine for about 20 years, reasonably happily, but then, it’s no surprise, I’ve found my way into policy. I passed Organic Chemistry only because a generous professor graded on a curve, so my 2 out of 100 on the major exam gave me a C. A quarter of the class got 0. The fact of the matter was I didn’t really deserve the 2. I was editor of the campus newspaper. So, my skills were not in science. They were in writing and stuff like that. My experience confirms that good physicians don’t have to have high science aptitudes.

Berkowitz:

So, speaking of Newark and Detroit -- do you remember what you were doing that summer of 1967? It would have been, I guess, before your senior year?

Berenson:

I spent part of it on a work study/pleasure tour of the Soviet Union, right after the Glassboro Summit Conference between President Johnson and Alexei Kosygin. John Coltrane died while I was on a 10 day boat ride down the Volga River, listening to the jazz band on board and stopping at local towns along the way. Drank a lot of vodka, toasting the Russians for “peace and friendship.”

Berkowitz:

You went to medical school in New York City and went on to become an internist. Was that clear from the beginning or were you toying around with other specialties?

Berenson:

No. I was never good with my hands. Being a surgeon was not anything that was appealing to me. In those days, internal medicine was much more prestigious than it is today. Those were the smart people, the people who think, and it got reinforced at Mount Sinai in my clinical clerkships that those are the most important doctors. So, it was just natural that I went into internal medicine, but even then, I had mixed interest. Roger Platt was a medical resident of mine who, after his internship, had come for two years into the public health service. He had gone into the ESRD (end stage renal disease) program at HEW (Health Education and Welfare, the predecessor organization to the Department of Health and Human Services), and I thought it would be nice after internship to also get

experience in the public health service, to get off of the standard route of work, work, work through internship and residency.

So, after internship at Montefiore in the Bronx, I spent two years in Washington in the Parklawn Building, in the Community Health Center program. We were actually the HEW staff to bring over the OEO (Office of Economic Opportunity) neighborhood health center program that had been founded as part of the War on Poverty.

It was in 1973 that I moved to D.C. -- the week that John Dean was testifying against Richard Nixon. It was a great year to be here, as Nixon was going down. It was tons of fun, and I decided I didn't want to go back to the Bronx. And I already had a sense that I could get involved with health care at a different level than practicing. I stayed in Washington, where I've been ever since.

Berkowitz:

So, what was your first Washington job then?

Berenson:

So, after the two years at HEW, I decided to finish residency training and was able to get the last available slot in the George Washington University internal medicine residency program because the guy who said he was going to stay decided to go to NIH and become a liver maven. So, I got the last slot, and I was able to complete my residency program at G.W. And then, the major thing that changed my whole career happened. G.W. was one of a handful of places around the country that was a site for the Robert Wood Johnson Foundation Clinical Scholar Program. They were selected because Steve Schroeder, who subsequently became the President of the Foundation, was a Professor of Medicine at G.W. Because of his influence, they decided to award this program to G.W.

So, I was accepted into the program, and a few months before I was to start, they decided to defund the program going forward, which meant we were a lame duck group. In short, nobody cared what we did during our two year fellowship, so instead of doing health services research in the clinic, I was completely free with a fellowship salary to explore alternatives, including in policy. Jimmy Carter had just been elected. The next thing I know, I'm getting a call from Joe Onek at the White House who was on the President's Domestic Policy Staff.

So for two years, the Clinical Scholar Program funded me to go work on the White House staff – very much like a White House Fellow. I never really learned how to do health services research. To this day, I don't really know what a regression is. Instead, I experienced an old-style apprenticeship. I just hung out on the White House Domestic Policy staff, initially with Joe, until he moved over to the White House Counsel's Office. And they hired me as a political appointee after the fellowship ended.

Then I worked with Jim Mongan. He wound up becoming the president of Partners in Massachusetts, and before that, Truman Hospital in Kansas City. But he had come from the Senate Finance Committee working under Senator Russell Long. And, so, I had a great experience doing that. It completely changed my career. Yet, it was pure serendipity. It was the only year of a Democratic presidency in 20 years. When Carter lost to Reagan, I was getting offers to go to work in law firms, and I had to tell people, "I'm not a lawyer. I'm

actually a doctor.” I decided I didn’t want to be a lobbyist. I was excited to go into practice, which had been my plan all along. But the White House experience permitted me to maintain contacts and become knowledgeable about the policy process.

Berkowitz:

I’m interested in this Carter White House experience. There was that doctor that got himself into trouble --

Berenson:

Peter Bourne.

Berkowitz:

Is that someone that you knew?

Berenson:

We certainly interacted because he was instrumental in forcing the issue between Kennedy and Carter on whether Carter was going to support Kennedy’s style of comprehensive health insurance. Peter was sympathetic to Kennedy. So, we interacted. There was a little tension because we had line responsibility for developing policy through Stuart Eizenstat, the Domestic Policy Adviser, and David Rubenstein, his Deputy, and Bert Carp, who was another Deputy. We had our line to the President through Eizenstat, but then Peter was off on the side sending his memos and talking to the President directly. So, it created a little bit of tension, but in general, it worked out pretty well.

Berkowitz:

So, can you tell me a little bit about the Carter effort on health reform? The story is that the President, like all Democratic Presidents, was interested in national health insurance, and he was also facing problems from Edward Kennedy. The bottom line was that it didn’t get passed during Carter’s administration. Then in the end he sort of asked for hospital cost containment as a first step.

Berenson:

Well, I would change the order of those things. He ran on hospital cost containment. During his campaign he did one speech to the Student AMA about wanting to do health insurance, but his Administration came out of the box with a hospital cost containment proposal that preceded anything on health insurance.

Within the health insurance debate, there were two major policy issues. The first issue was this: do we proceed with health insurance expansion without cost containment or is cost containment a requirement before we do health insurance? The second issue was the debate between “catastrophic” versus “comprehensive” insurance. That was a dividing line between Kennedy and Carter. The President didn’t think we could afford to do comprehensive initially.

People were coming up with notions of triggers for insurance expansion if costs are held under x. On cost containment, in ‘77 and ‘79 there were two major legislative proposals. There was never a full health insurance proposal from the Administration. I didn’t quite understand how this came about, but Secretary of HEW Califano set up a series of papers

with outside experts to advise on options for health insurance coverage. It's where Alain Enthoven first presented his notion of a competitive health system.

The outside papers was a way to buy time until the health insurance decision was made in like, oh -- probably late '78, early '79. One of the highlights for me of my White House staff experience was the meeting with Carter, Kennedy, Mondale, and Meany, and numerous others. I was sitting in the corner. The main players were heavy weights in the Democratic Party; the meeting went on for about two hours. They did not come to an agreement. The next thing we knew, Kennedy was running for President. That became his rationale for running against Carter -- Carter's unwillingness to support comprehensive health insurance.

Berkowitz:

So, another thing that happened during the Carter years we probably should mention is the creation of the Health Care Financing Administration. It's often presented as the Joe Califano initiative. Do you have any sense of that?

Berenson:

I don't. I think it might have been a Califano initiative, but I don't really know.

Berkowitz:

So, that wasn't primary in peoples' consciousness in the White House?

Berenson:

Oh, probably but not for me, personally. When that happened, I was still a clinical scholar and was given special projects to work on, but I didn't have access to all the decision making that Joe Onk would have been involved with. So, I don't know how HCFA came about. But if you remember, Carter was committed to "cabinet government" -- until it all blew up. He wound up firing three cabinet members, including Califano.

Regarding cabinet government, Secretary Califano actually sent a memo out to all of his senior staff at HEW saying, "Nobody is allowed to talk to Joe Onk at the White House without my permission." Now, it happened that Onk was best friends with Ben Heineman, who was Califano's top Special Assistant, and they were talking all the time. Looking at it based on my experience in the Clinton Administration and now from the outside looking at what happens now; it's fanciful that the White House would be told that they're not allowed to call over to HEW. Now, the White House directs everything. In those days, clearly, this level of White House control hadn't happened yet.

Berkowitz:

I see. It's very interesting, too, because Califano had been the White House person and he knew his way around.

Berenson:

Oh, that is right. So, since he had been doing it for Lyndon Johnson, he knew that he didn't want the White House directing his agency.

Berkowitz:

So, as I understand it, you finished your program at the White House and went to the actual practice of medicine.

Berenson:

Yes. I started as a staff physician at the George Washington Health Plan which was a closed-panel HMO, and I actually had been working there half a day a week all through my White House period as a requirement of being a clinical scholar. I had to do some clinical. So, it was actually pretty unusual to be seeing patients in the morning, walking nine blocks to the Old Executive Office building where our offices were. So after President Reagan took office, I returned to the Health Plan for a few months as a staff physician. A colleague and I decided to start a practice on Capitol Hill in 1981, which is still a thriving practice. We set up across from the Eastern Market on Capitol Hill. A great place to practice – one of the few areas in DC then with a mixed patient population – old and young, rich and poor, straight and gay, making the clinical work diverse and interesting.

Berkowitz:

Was the next thing you did the National Capital Preferred Provider Organization?

Berenson:

That started later. As a part-time thing, I helped organize a PPO, a rental PPO, where our major funders were the Mass Mutual and the Hartford, who subsequently both got out of the health care business as it was consolidating now to only a handful of insurers. But we were a rental PPO, and it was quite successful. I would spend maybe two half days a week doing that while I was being a part-time medical director while I was in practice. My practice on Capitol Hill was my main activity. And that went on for 12 years, basically.

Berkowitz:

But then you somehow got involved with President Clinton. How did your contact with him begin?

Berenson:

During the campaign, I was one of a group of policy veterans who thought we should be advising any Democratic Presidential candidate. I had actively worked on both the Mondale and Dukakis campaigns in '84 and '88. It was all voluntary, but substantive (to the extent that anything substantive takes place in political campaigns).

So, when Clinton comes around, I'm one of the people who David Broder and Haynes Johnson in their book called "the Blue Doughnut Group." There were a handful of us who met at Bruce Fried's office. He worked at Wexler and Associates. There was Judy Feder, Jack Ebeler, Joe Onek, and a few others -- informal health policy advisers to the Clinton Campaign. We would be on the phone to Little Rock with a guy named Atul Gawande, some "kid" who was going to direct us DC veterans on health policy. I didn't meet him until after the election. We became very friendly after the election, perhaps partly because we were physicians in a world of economists and lawyers.

After the election I was wondering whether I would go back into the administration in some role. I used the election and my work on the transition to retire from practice. Unfortunately, the Presidential transition was sort of a mess because Ira Magaziner, who

subsequently ran the whole health care reform activity, elbowed out the transition team for access to the President. Larry Lewin, Stuart Altman and Judy Feder were the senior people I was working with on the transition team. All of the extensive transition documents we produced were ignored by Ira. I went my own way after the Administration took office. But I was a doc, and there were no other docs around. And so I got a call one day very shortly after the President took office to join the Health Care Task Force, and I became one of the 500 who hung out for three months in the Old Executive Office Building, working on health care reform.

Berkowitz:

And this is phased in with the First Lady's efforts of --

Berenson:

This is the First Lady's effort. Ira Magaziner was the First Lady's person to run the process. So, it was basically, the First Lady and Ira doing health reform.

Berkowitz:

So, in retrospect, was that a good decision, to put the First Lady --

Berenson:

Clearly not. As we said at the time, somebody like the Treasury Secretary-- in this case Lloyd Bentsen--can't go to the President and say, "I think this is way off track." It makes it very difficult to give candid advice to the President, when his wife is running the Task Force. Decisions were being made not to compromise, not to try to get support from the moderate Republicans of which there were still some, like (Lincoln) Chafee (R-RI) and (David) Durenberger (R-Minn). It was a Democratic approach. But even a lot of Democrats got ticked off largely by the way that Ira managed the process.

Berkowitz:

So, in this decision to make it in the White House and then send it to Congress that was a big decision of the time that people, in retrospect, was the wrong decision?

Berenson:

Right. I agree with that analysis. They were into writing a 2,000 page bill, which is the Congress's function.

When I showed up, there were already hundreds of people who had been assigned to work groups. I remember this -- there were 39 of them, 39 different work groups and I show up and say, "You don't have anything here on antitrust?" Or about fraud and abuse, sort of the legal stuff. So Ira says, "Good, you can head up the 40th work group." And so, I wound up being the co-chair of one on malpractice reform and the other on antitrust and related legal issues.

On the latter work group, I became friendly with a Department of Justice antitrust attorney. A couple years later, we're having dinner with his wife, reminiscing about our experiences on the Task Force. And at one point, she interrupts, "Wait a second, let me see if I have this story right. They actually did have a doctor on the Health Care Task Force and had the doctor do all the legal issues, is that what you're telling me?" And that's basically right.

I had to go in there and tell them that you really can't move to a competitive health system without thinking about antitrust and related issues.

Berkowitz:

It becomes a model for future efforts of what not to do?

Berenson:

Yes, what not to do. I think there is a conventional view that Obama went too far in the other direction-- but clearly, in the Clinton case the White House had overreached.

Ira had this intellectual arrogance where he thought there was a correct answer to everything, when many things are political decisions, political judgments often reflecting different policy values. He thought there was a correct answer to every question. I was in charge of the malpractice reform effort, and Ira had trouble accepting the fact that people had really different views about the role of malpractice. You had the trial attorneys who had great influence with the Administration, who didn't want to see any tort reform of any kind, and then you had the academics who came up with other ways to do it like "quasi-no fault," taking it out of the courts altogether.

So my work group of about 12, 14 people could not agree. We had people who worked for Senator (Howard) Metzenbaum from Ohio (Dem) who didn't want to see any change to the legal system and people like me who had these grand schemes for alternatives, however politically problematic. We said to Ira, "We can't get an agreement." And he said, "Well, I'm very disappointed in you but if you really don't think you can find a compromise, then present the different points of view." He actually thought there was a correct answer to every one of these challenges, rather than accepting the fact that values differ and politics is involved.

Berkowitz:

So, now in the Clinton Administration, though, you actually do get involved?

Berenson:

Five years later, at a time when the Administration had developed a high level of competence. So, for a few years there, I was sort of under-employed. I was working at NCPPO (National Capitol Preferred Provider Organization). I was writing some policy papers. And I started working at Lewin (a health policy research and consulting firm) in '97. Very shortly thereafter, I got a call from Bruce Vladeck.

Bruce was the Administrator at HCFA, and this was about the fifth year of the Administration. He wanted to talk about me becoming the Chief Medical Officer at HCFA. I liked Bruce and I was attracted to it, but he was walking out the door. So, it didn't make a lot of sense that I would take the job. I had also just started working at Lewin and felt I couldn't just leave.

A few months later, I got a call from Nancy Ann DeParle. Even though we were both on the Health Care Task Force, I hadn't actually met her. There were 500 people, passing in the hallways. She called me and said she'd been talking to the Deputy Secretary, Kevin Thurm. She had just been announced to become the Administrator of HCFA, and they

wanted a doc as the deputy. That's where I came in. She said in effect, "You're one of the few Democratic doctors anybody knows." We talked about it, and it was inconclusive. She hadn't started yet, and we said we'd keep in touch.

When she got back to me a few months later as the Administrator, now in early 1998, she said they had reconsidered, and they didn't need a doc in the deputy job. But they had a different job in mind for me if I was interested, which was basically in charge of Medicare payment policy and managed care contracting within HCFA. This was more appealing to me partly because I had learned that I was much more comfortable with policy, accepting that politics always play a role in policy-making, than I was in the pervasive role of politics in administering Medicare, which the Administrator and Deputy Administrator deal with. I was in charge of payment policy, and so, I moved over there in April of '98. In fact, the same week, three political appointees showed up. Nancy Ann was over there by herself for months with virtually no other political appointees. Mike Hash, Carol Cronin, and I showed up the same first week in April of 1998. I was in charge of what's now called CM, the Center for Medicare. It wasn't exactly that in those days. It was the Center for Health Plans and Providers.

Berkowitz:

How did that organizational change come about?

Berenson:

Bruce Vladeck did a whole reorganization that led to there being a Center for Health Plans and Providers. Tom Scully rearranged things in a different way later.

When Vladeck made his organizational changes, there was the Breaux-Thomas Commission, which was set up to talk about the future of Medicare. There was active talk about not trusting HCFA to give a fair shake to private health plans. They were talking about having a different entity -- that HCFA would administer traditional Medicare and a different government agency would oversee the competing, private health plans. The Breaux-Thomas stuff was part of premium support discussions: the idea of having competition amongst private plans and minimizing the role of traditional Medicare.

Bruce produced what's called a functional organization model, putting activities related to private plans spread out throughout the whole organization. He apparently saw that as a way to preserve that function (overseeing private plans) within HCFA because the reorganization would make it hard to just pick the private plan activities and move them out. That was, as I understand it, one of the reasons he did this reorganization. That reorganization was undone as soon as Tom Scully came in under Tommy Thompson. But at the time, it was Health Plans and Providers, which meant the Medicare + Choice Program, which had been created in the Balanced Budget Act of 1997. Before then, it was known as the TEFRA (Tax Equity and Financial Responsibility Act) risk program.

It was given a new name in the BBA and a new payment model, but for 20 years Medicare had been contracting with private plans. It got a new name and then, subsequently, got another new name, "Medicare Advantage," in 2003.

The job also involved all Medicare payment policy. A key thing about the BBA was that virtually for every provider type a new payment model was called for, a new prospective payment approach. Nancy Ann actually had somebody add it up, and we had something like 330 different major provisions to implement in Medicare and Medicaid as a result of the BBA. But mostly, it was in Medicare, and so my three years there was almost all about developing regulations for the new payment models.

Unfortunately, the Vladeck reorganization split off oversight of the administrative contractors, then called intermediaries and carriers, and gave it to a different entity, the Center for Beneficiary Services. So, there was this weird thing where I was in charge of policy, but not implementation of policy by the contractors. I would get invited, occasionally, to come speak to them or had contact with a medical director at the carriers. But one of the downsides of that reorganization was splitting off policy from operations. I did not have authority over the contractors, and that was a mistake. Scully put that back where it belonged.

Berkowitz:

I think of Medicare + Choice as associated with Newt Gingrich. He was enthusiastic about ventures like that. Is that correct?

Berenson:

The focal point at that point was really Breaux- Thomas (the Commission on the Future of Medicare). Breaux- Thomas was very important in all of that. Newt did have this famous line, which Democrats trumpeted politically, which is something like “We won’t legislate the end of Medicare; we will let it wither on the vine.”

And he actually meant it. In fact, that to some extent is happening now and has been in recent years. Not surprisingly, if you overpay the private plans and make it so much of a better deal for beneficiaries-- as much as \$1,000 extra in benefits at its peak in 2005-- people will move from traditional Medicare to a private plan; people will just vote with their feet and traditional Medicare will wither on the vine. That’s what I think he had in mind.

Bill Thomas (Chairman of the House Committee on Ways and Means) (R-Cal) was a very smart guy. In all the testifying I did -- and I probably testified 12 or 15 times -- he was probably the smartest guy; he actually knew detail, which most of those folks didn’t. I think his notion was to initially overpay the plans to get them out there and get them enrollment. But over time, he thought Congress could cut back those overpayments, and the plans would have to compete reasonably. The problem with that is the industry doesn’t want to just give up their overpayments. But in any case, the one thing I associate with Gingrich is this quote about Medicare withering on the vine.

Berkowitz:

Looking at your time at the Center for Health Plans and Providers when you were putting the Balanced Budget Act regulations in place, was there one that most interested you?

Berenson:

Well, I was most interested in the physician fee schedule. That actually wasn’t created by the Balanced Budget Act. Previously there was put into place the RBRVS system—

resource-based relative value scale. The change that came from the BBA was moving to what became known as the sustainable growth rate.

The first thing I did when I showed up at CMS, was do the “fly in” to the AMA in Chicago, defending what happened before I showed up, which was developing documentation guidelines for justifying coding; this was the real in the trenches, in the weeds stuff. But I had to defend these new coding guidelines.

I became convinced that these documentation guidelines were flawed and likely counterproductive and that the whole fee schedule needed special attention because it was tilted in favor of specialists against primary care, in favor of procedures and tests and not time spent with patients. I spent a good part of my time there trying to do something about that and failed completely. Even now, we still have the same thing going on; it hasn't changed since then. And, I spend some of my time now continuing to work on that issue.

Berkowitz:

What were the patterns of communication and policy development on that issue? Whom were you talking to?

Berenson:

Well, there was sort of an unstated understanding, which basically said we have to be friendly with the AMA. It's because, at the time, there was a Patient's Bill of Rights as part of the managed care backlash. The Clinton Administration and the physicians were in concert, wanting to put some limits on managed care autonomy. So the Patient's Bill of Rights became a major priority of Secretary Donna Shalala and of the Administration. It became clear to me that I wasn't to pick a fight with the AMA over the fee schedule. The reason I'd have to pick a fight with the AMA is there is a committee under the auspices of the AMA comprised of all these specialty society members that had – and has -- inordinate influence on HCFA's decision making around the fee schedule.

To take that on would have meant taking on the AMA politically. The word was -- I don't know that I ever heard this, but I understood it-- we're not having a fight with the AMA. This is one of those times where the interaction between politics and policy is direct. You need to understand that you can't always do the right policy because the Administration has other priorities. You are part of the team.

Given that context, there still was an ability to do rule-making every year, to put out proposed rules, which could make changes in the actual implementation of the fee schedule. To make incremental change. There, the barrier to change, I think, was staff-- perfectly good civil servants who had different priorities than I did. So, I'm looking for a major change in the payments, and staff is looking to minimize controversy. Typically, staff would produce an impact analysis reflecting all the discrete decisions on fees -- So the analysis would tell us how the distribution of payment changes by specialty?" And invariably, staff would say, "Whoops, too much change. We've got to change our assumptions so that there are no big winners or big losers."

That was when I understood that political appointees have to selectively pick the issues they are going to be dauntingly fighting for because you have a certain inertia that happens in any government agency. People will outlast you, and there were clearly some issues on which I knew that staff was just slowing down the clock, memos that were supposed to show up somehow weren't showing up, and my time was limited. And so, it'd only be a few issues, and this is one I actually did put on my top list but wasn't very successful. We didn't have a good alternative to over-dependence on the AMA committee.

Berkowitz:

So, at the end of the Clinton you served as Acting Deputy of CMS?

Berenson:

Yes. Nancy Anne left in September, 2000. Mike Hash became the Acting Deputy, and then he left around December, some sort of Hatch Act violation--a technical violation. And so, I was the last person [laughs] standing. It was after the election. I was the Acting Deputy for 5 or 6 weeks. I had moved over to be the Acting Deputy when Mike was the Acting.

Berkowitz:

This was around the time that the election was being contested after Election Day. Did that affect your job? The new Administration's coming in. It's trying to make its transition, meanwhile, not being exactly sure whether or when they're going to take office. Were you part of discussions with the Bush 43 Administration?

Berenson:

Just near the end when their transition folks came by. I think the Florida controversy with the disputed ballots, the hanging chads and so forth, delayed everything a number of weeks. We didn't have a lot of interaction with the transition people. My major job was to decide on who, from the staff, would be the Acting when I walked out the door. Michael McMullen from the career staff was the person. She clearly was the right person for that. We only talked internally. I had very little contact with the Bush folks. I don't even remember having contact with the Bush folks, but I'm sure it happened.

Berkowitz:

So, you were in the top position at HFCA for the last weeks of the Clinton Administration...

Berenson:

Yes, it's very liberating to be in that position after the election. I still remember the day when a Congressman from New York called wondering what the decision was about some requested favorable treatment for the hospitals in his district. We weren't going to give favorable treatment. The call comes in, and I said, "I'm not going to take this call." Well, what's he going to do? Report me? It was three days before we were walking out the door. It's an unusual time to be the Acting Administrator: politics, no more;

Berkowitz:

Before we end the interview, I would like to talk a little bit about the Affordable Care Act, and maybe you could tell me about whatever involvement you had in that exercise?

Berenson:

I was actually part of the Obama transition team and two of us did CMS. We interviewed a lot of folks. I came to the conclusion that it was largely an exercise in rewarding loyal people in the campaign [laughs] to let them feel they were part of the transition. That was consistent with my understanding from the Clinton transition. All this work going on doesn't matter because it will be the people who actually get put into the permanent positions who will determine things. So, that ended, and I had no formal ties with the Administration at all from the day I left the transition team.

You go from working 12 hours a day to, "Thank you very much. We'll call you." And so I became an outsider. I had ties to the Hill. I had ties to the Ways and Means staff while there was still a Democratic majority; I had ties to the Senate Finance Committee, to some extent, and on a few issues that I cared about. I spent some time with staff on the Hill to develop language. Mostly, I worked with Ways and Means staff, but then the Affordable Care Act came together using the reconciliation process and having to take the Senate bill as it had passed the Senate. There was no conference. All this work that I had been doing that showed up in the House bill was for naught.

Berkowitz:

There was a sidecar bill, though, wasn't there, also?

Berenson:

Well, there was a very small sidecar bill on major provisions, but I was really working in the trenches on doctor payment and stuff like that that was not part of reconciliation.

To me, the Affordable Care Act is in two completely different parts. One is coverage expansion, which I don't work on, while a lot of other people at the Urban Institute do, and I think that's the big success of that bill -- coverage expansion. The other part is delivery system reform, which is largely around new payment and delivery models in Medicare. I've been something of a friendly critic about how that's been implemented. It ultimately shows up in this 2015 SGR (Sustainable Growth Rate) repeal bill with bipartisan support and (Nancy) Pelosi (D-Cal) and (John) Boehner (R-Ohio) walking arm-in-arm. But I am troubled by the core of the bill involving physician payment in Medicare. I think people are wildly exaggerating the opportunity to measure performance; pay for performance is an unproved concept, and it doesn't seem to have worked in education.

People in health care have glommed onto the approach, but behavioral economists challenge its validity, concerned about how professionals will actually respond if you pay for performance on certain specified areas. Do you compromise intrinsic motivation that professionals have to do a good job? I share that concern. I think the measures are currently lousy. There's this cliché that goes around, which has just become common, "that you can't improve what you don't measure." I think that's wrong. We improve lots of things we don't measure every day. As a physician I could relieve patients' pain without measuring anything. We've become hostage to all these measures. CMS is the leading cheerleader for it all, and while I'm friendly with the people at CMS in senior positions and have candid conversations with them about so-called "value-based payment," in most of my writing and speaking, I'm somewhat critical of how it's being implemented. It's aspirationally right but operationally, I think Congress and CMS are making some bad

decisions. But the support for the approach is bipartisan and bicameral. I think there's a broad agreement to move in a direction that I don't think is achievable.

Berkowitz:

You're now working at the Urban Institute?

Berenson:

I'm an Institute Fellow at the Urban Institute, yes. I've been there for about 11 years, now.

Berkowitz:

So, after the experience at HCFA, -- what was your job right after that?

Berenson:

Oh, for a couple of years, I was independent. I hung out at a place called Academy Health, which is the Association of Health Services Researchers. I mostly did independent policy writing. And then Urban offered me a job, which made sense, and I went to Urban. I've become an academic sort of late in life.

Berkowitz:

You said that you have concerns about pay for performance and related mantras or slogans about how we should pay for Medicare, such as not just pay for volume but pay for value.

Berenson:

Yes.

Berkowitz:

So that raises the obvious question, which is what should we do?

Berenson:

I argue, and this is a theme that I've already presented, if we could actually correct the distorted fees and the physician fee schedule, that would dramatically change how doctors actually spend their days. If they were paid to spend more time with patients instead of ordering lots of tests and doing unnecessary procedures, it would improve value a lot more than picking a couple of half-baked performance measures and claiming that we are holding physicians accountable for quality. I would do the blocking and tackling, real detailed work on the Medicare payment fee schedule. I can get a lot more value out of fixing our current payment systems, but that is not considered value-based payment.

Aspirationally, I'm all in favor of moving towards larger systems that take financial risk and are accountable for their quality. I actually think there's some hope of measuring quality at the organizational level, not at the individual clinician level, and that can be going on also but probably would not apply to the majority of doctors or hospitals in the country. It would apply to those organizations that have a culture and a commitment to moving in that direction. Most don't. So, fix what's broken. There's this view that the politics of fixing what's broken in our legacy payment approaches is impossible so we're now going to invent something else; but with the new approaches the politics will be just as bad. The doctors who are earning \$700,000 today providing services that may not be particularly

useful for patients aren't going to sit around and just accept the fact that they're now going to be part of some mega-organization which is being paid in some new way. I just find there's too much magical thinking going on.

Berkowitz:

That's a great note on which to end. Thank you so much.

Berenson:

Thank you.

Interview with Donald Berwick

Washington, DC on May 4, 2015

Interviewed by Edward Berkowitz

Transcript edited for clarity.

Berkowitz:

Today is May 4th, 2015, and we are at the headquarters of the National Academy for Social Insurance in Washington DC, and I'm talking to Dr. Donald Berwick. I'll start with some biographical information. Your dad was a doctor in a town which I take to be near Middletown, Connecticut?

Berwick:

Yes, a town 17 miles south of Middletown called Moodus, Connecticut. He was a general practitioner there for over 40 years.

Berkowitz:

Was that an inspiration to you?

Berwick:

Yes. I never actually thought about being anything but a doctor, probably influenced by his example in the town. He was one of two country doctors, a general practitioner -- he did everything. In those days you could, and he loved his work, and he was a role model for me in terms of my professional intention.

Berkowitz:

Did it make you more skeptical about specialization in medicine?

Berwick:

[laughs] It made me really recognize the value of generalists. You need specialists, too, but my father was a support to the whole town. People turned to him in all sorts of distress, and he was able to integrate his knowledge of the circumstances of people and their lives. He knew what to do for whom and I think that role, that connectedness to community, is very much my image of doctoring. It's not anti-specialist at all. He relied on specialists of course, but when it comes down to the important moments in peoples' lives, having someone who knows you that well really matters.

Berkowitz:

So you were educated very much at Harvard: undergraduate, medical school, residency, and the Kennedy School. Is there something particular that you got from this Harvard education and its various levels that you took away and put into your subsequent work?

Berwick:

Yes, in many ways; remember, I came from a small town. My graduating class was, I think, 49 people. I came to the university from this small town background, and it was such an intellectually rich environment. I got exposed to things I never imagined existed. My freshman seminar was taught by Roger Fisher. He put together a group of a dozen freshmen to write a book with him on conflict resolution. That was the kind of experience I was having. I got exposed to the classics in humanities, and I was briefly a government major and then switched to a psychology and sociology combined major and I loved it. That was formative, just mind-opening. Harvard Medical School was a great place to be trained. There was obviously the best science, but also I had wonderful mentors there, and people who gave me an image of how to act on the value structure of a professional and be the doctor I wanted to be.

Probably the most formative experience, though, was my year at the Kennedy School. I had a joint medicine/public policy degree, masters of public policy from the Kennedy School. I did them simultaneously, and the Kennedy School at that time had just started a public policy program. I was in the second year of it ever, and that was completely eye-opening. I was taught economics, statistics, operations research, and policy analysis by the masters -- by the great names in the field: economics by Tom Schelling and Francis Bator; conflict resolution by Richard Neustadt; and operations research by Howard Raiffa and Dick Zeckhauser. And so I was being given a set of tools I didn't know existed; then when I went back into medicine, everything I saw in medical care as a doctor, I was also seeing through this set of lenses that I was given in the public policy program, and that shaped my career.

Berkowitz:

Interesting. Your specialty was pediatrics?

Berwick:

Actually, I trained in internal medicine for one year before that and then switched to pediatrics, and that became my specialty -- general pediatrics. I did a residency and fellowship in general pediatrics.

Berkowitz:

Pediatrics also has a kind of connotation of not quite as specialized in a certain sense, more caring for the whole patient than the rest of medicine?

Berwick:

Yes, it's a generalist field. But the other thing about pediatrics, it's a systems clinical science. You're dealing with a family system, multiple generations; the kids are strongly affected by environment they're in--the education system, poverty. So I think it further deepened my interest in systems as well as doctoring.

Berkowitz:

At some point you went to work for the Harvard Community Health Plan, which, as I understand it, is an influential HMO. I've always been curious about the relationship between Harvard the University and this Harvard Community Health Plan. I assume some of the same folks from Harvard were involved in setting up the Harvard Community Health Plan. Or do I have that wrong?

Berwick:

No, you're right. Just to clarify the trajectory--I finished my clinical training, but I didn't go directly to the Harvard Community Health Plan. I went to the Harvard School of Public Health and the Harvard Medical School. I became a young faculty person teaching pediatrics in the Medical School and Children's Hospital, but my main work was at the Harvard School of Public Health, where the new dean, Howard Hiatt -- Dr. Hiatt-- had set up a center for the analysis of clinical practices. Because of my Kennedy School background, he asked me to come there to help set that center up and to work with him as dean. So that was a period of about four or five years where I was at the School of Public Health as a young faculty person, learning and practicing methods of policy analysis and clinical evaluation. That was where I wrote my first book, which was on screening of children for cholesterol. It was an extended policy analysis of what to do with that possibility; I wrote it with Shan Cretin and Emmett Keeler.

Then I went to the Harvard Community Health Plan. They had set up a research unit, and they needed a director of research and I went there as acting research director. I got assigned to be head of their quality functions; it came with the territory and that was the beginning of my interest in quality. The Harvard Community Health Plan was the brainchild of the dean of the Harvard Medical School at the time, Dr. Robert Ebert. So the Medical School set it up, but it was a wholly separate organization, and by the time I was there, completely separate, no real relationship at all, except the name.

Berkowitz:

But it eventually became pretty influential in the Boston community didn't it? --

Berwick:

Oh, yes. It became the largest HMO in New England for quite a while. It doesn't exist anymore, but at that time it was in its ascendancy. It was proving, as Dr. Ebert had predicted, that you could really organize care and reduce cost and improve quality by doing that. It grew very fast while I was there. It did retain ties to the medical school; for example, the research unit that I set up had strong ties to the Harvard Medical School, and eventually a department of the Harvard Medical School was put in the HMO to oversee primary care.

It became a pretty important organization in its time. It was run very well by an executive who really saw a vision. It then entered a series of mergers. Instead of remaining a pure staff model HMO, it merged with a group model HMO, MultiGroup, and then shortly after that it merged with essentially an indemnity insurance company that had a managed care product, Pilgrim Health Care. I had left by then, but it split and then the doctors decided to leave and form their own integrated group, Harvard Vanguard, leaving the insurance structures with the organization that became Harvard Pilgrim Healthcare.

Berkowitz:

I see. This was a time when there was a lot of interest in HMOs, both public sector and private sector. In your mind, was this a model for the future of healthcare?

Berwick:

Well, it's the only place I ever practiced medicine actively. I was a pediatrician there for 20 years or more. And it was a terrific place to practice. I felt then and I still feel now that the circumstances I practiced under were ideal for me as a clinician. I was on salary. If I ordered a test, I didn't make more money and I didn't make less. I just had to figure out what to do for a kid. Care was integrated, so if I needed the help of specialists or a home visitor or social worker, it was literally right there. The social workers were down the corridor when I had a kid who was depressed and needed help with, say, behavioral healthcare. The allergist was upstairs and he would come down to see me when I was dealing with a kid with an asthma attack. The integrated care, the incentive structures were great, and then I had support. I could learn.

They even had an electronic record, one of the first. So I never lacked the patient's record. It was always there on my computer screen. And it had an education system that was terrific. Two things happened to me. One was I eventually became the first Vice President of the plan for Quality-of-Care Measurement, and they put me through a one day a month management training program; I still use what I learned there. And they also had data feedback. So I remember one time -- I remember this vividly--I got a report on my use of chest x-rays. Remember, there was no financial incentive here; it was just they reported back to me on my use of chest x-rays. It turned out I was ordering x-rays a lot more than my chief, who I thought was a terrific pediatrician. I wouldn't have known that if I hadn't gotten the feedback, but I got it, walked into her office, I said, "What's going on here? I'm ordering a lot more chest x-rays than you." She sat me down and she said, "Well, how are you using them?" It turned out I was making some mistakes. I had misunderstood some things about chest x-ray performance in kids, to my embarrassment, and she corrected me. And so it was a terrific place to practice. I think it still to me is as good a model as I've ever seen.

Berkowitz:

Did you have peers, other organizations you considered your peers?

Berwick:

There was a cluster of staff and group model HMOs, where the docs operated under similar circumstances as we did. They were integrated, they had histories. Harvard Community Health Plan, in fact, was the newcomer. I think it started in maybe 1969 or something. But there were Kaiser Permanente, Group Health Cooperative of Puget Sound, and Health Partners in Minneapolis--a small number that were similarly inclined. I didn't know that as a practitioner, but when I became a researcher and got interested in quality, those were the natural siblings. For example, what Group Health Cooperative of Puget Sound had by then done on prevention in antismoking and breast cancer screening-- it was leading, not just the nation, but in some ways the world. And it was no accident it was coming out of an integrated prepaid group practice.

Berkowitz:

So you became Vice President at Harvard Community Health Plan. How were you dividing your clinical and your research interests at this time? Were you still seeing patients?

Berwick:

Yes. That was the tradition at the time. Every physician corporate officer still maintained a clinical practice.

I went there in 1981, I think was it. I wasn't Vice President at that time; I was brought there because of a crisis. The HMO had lost money for the first time in its history, due to poorly modeling its hospital use, and so the board changed structure. It put a layperson at the top instead of a coequal medical director and CEO. They changed the business model; they had to focus hard on cost, and they were very worried they would injure quality by focusing too much on costs. They knew my background, which was health services research, quantitative methods and clinical competence, and so they brought me in to watch the quality. I was to make sure that while they were working on the finance they weren't injuring care. That was my assignment.

They rapidly elevated me to a vice presidency, reporting directly to the CEO because they were really worried. My assignment was to develop a metrics system that would allow the board of trustees and the senior executive and clinical leadership to monitor the quality of care. That was the time at which the RAND health insurance experiment had reached its maturity under Joe Newhouse. As you may know, probably its major contribution wasn't what it was originally set up to do. It originally set out to study the effects of insurance copayments and deductibles, but it actually birthed the modern toolkit of metrics. I knew it well from my research, so I was able to draw on the RAND health insurance experiment results, then rapidly after that the Medical Outcomes Study that Al Tarlov headed. They gave me all the money I wanted to do it.

I was set up quality-of-care measurement as Vice President, and began to report. For four or five years we produced probably the most expansive reports on quality within an organization of scale that anyone was able to do. It was quite an interesting assignment. The problem was most of the metrics that I was watching weren't changing. They were stable at fair to good. That was basically where we were, no matter what we were looking at: screening rates, infection rates, complications of delivery, surgical complications, patient satisfaction; I got very frustrated by that. I thought I was wasting my time. We were measuring and nothing was changing, and that led me -- well, first to quit. I went to the CEO and tried to resign; he said, "No." He said, "Why don't you instead study other industries?"

His assignment to me was go take whatever time I wanted. He said, "Go anywhere you want and find out how other people look at performance." And I did. That was 1985 we're talking about. And I began a journey worldwide looking at quality of management approaches outside healthcare.

Berkowitz:

Turning now to the National Demonstration Project on Quality Improvement in Healthcare-- I believe you worked on that from 1987 to 1991. I was struck by the fact that the supporters of it, the donors, the people who gave financial support, a lot of them are private companies. Is that right?

Berwick:

Sort of; I'll explain how it was. So we're now in 1986, and I had done this investigation of improvement approaches outside healthcare: Sheraton Hotels, Swiss Air, NASA, Bell Laboratories, Gillette Company. I'd gone to place after place to figure out how they made things better. NASA got us to the moon and the question was, how? It was an amazing period; I learned a lot.

I knew NASA had acquired a reputation for doing things right. This is pre-Challenger, before the Challenger accident. I called NASA and I just said, "Could I speak to the head of quality?" I didn't know even what I was asking. They connected me to a man named Haggai ("Guy") Cohen. He picked up the phone; he was the head of quality for NASA: quality, safety, and reliability. So I told him I was from medicine. We were stuck, and how did they do quality, how did they think about it? He said, "Well, when can I come?" So he -- I think two days later--flew up to Boston. He sat in a room like this and brought maybe 400 overhead transparencies -- remember those?

Berkowitz:

Yes.

Berwick:

Guy talked for four hours and lectured me on the NASA quality system, and it was like a religious experience. I've never experienced anything like it. I saw a complete system for managing excellence to parts per million reliability; the space shuttle has a million parts and it generally works. Guy described to me not just the technical approach, but the managerial approach and the cultural approach to excellence at a level that was really world class. I had never seen anything like it.

Similarly, I knew that Bell Laboratories had been the home of quality disciplines for decades, and so I did the same thing: cold-called them. The guy that answered the phone is named Blanton Godfrey-- A. Blanton Godfrey-- and he's now become a close friend. I said, "I'm from healthcare; can you help?" He said, "When can you come here?" So I went down to Bell Labs within a week, and he set up a full day at Bell Labs to describe modern approaches to quality. Again, these are technical, managerial, and cultural approaches that are very well-designed. They're really, really powerful and scientifically grounded. I also met Paul Batalden, who became a close colleague, and he introduced me to W. Edwards Deming. I came to Washington and took a four-day course with Deming in 1986.

Deming was one of a couple of people in the postwar era who, as young statisticians, went to the Department of Agriculture and were sent to Japan to help with postwar reconstruction. In Japan, he and others either developed or got a chance to express their views of what it would be like to organize companies or organizations around excellence with respect to the customer, the person you're serving. So he developed his theories, and the Japanese bought them. They liked it. And the general belief is that's what accelerated Japanese industry to overtake U.S. industry in the '70s. But it wasn't done in the U.S. Deming was persistent, and eventually Ford Motor Company was the first American company to really embrace his theories, beginning a long turnaround.

His protégé at Ford was Jim Bakken, who became persuaded by his theories and he and Deming brought them to Don Petersen, who was the head of Ford. So they began a

change and -- because Ford had so many suppliers, once Ford decided, it moved upstream into manufacturing. Anyway, long story.

I got familiar with all that in 1986, '87, and by then I had come to know A. Blanton ("Blan") Godfrey, who was the head of quality systems and theory for Bell Laboratories. Blan and I cooked up the idea of setting up a national demonstration project on quality improvement in health care. The concept was I would find what ended up being 21 hospitals or organizations that had a chronic problem that they couldn't solve. And Blan found 21 experts from the field of quality and other industries from IBM and Corning Glassworks and Bell Labs and University of Texas, University of Tennessee, Fordham. We got the companies to donate time. They would donate their quality specialists to a hospital for a few weeks.

So we paired up hospitals and industrial quality theorists. And they went into the hospitals with the intent to help them with the new quality tools to tackle a problem they hadn't been able to do before. That was the National Demonstration Project (NDP). The funding for that was \$250,000 from the Hartford Foundation that we got with one phone call. I called Dick Sharpe there and he gave us the grant. So Blan and I were the Principal Investigators for one year, or nine months, on this NDP. It was so successful that we wrote a book on it and the Hartford Foundation came back and extended it for three more years.

So that was the period you were referring to. And that second period, that three-year period, we continued the demonstration but we also added in courses. We developed courses; we developed what became the national forum, wrote more papers, and that was '87, '88, '89, '90. And I continued to see patients during that time.

Berkowitz:

I'm struck by the fact that your one of the examples, one of your primary examples, was a government agency. You don't usually think of the government as a model for quality.

Berwick:

In this case, that's not the case at all. NASA was setting the standard internationally. It was really unbelievable in the quality field.

When Kennedy decided to go to the moon, I think you may know, Jerome Wiesner -- this was before he was President of MIT -- was his science advisor. And Wiesner -- the legend is, he headed a group at Kennedy's request to estimate the probability that they could get to the moon and back successfully, which he (the President) wanted to announce, and did. The probability came back at five percent. There was 95 percent failure chance. Kennedy ordered the report not to be published, is the story I've heard, and instead they went ahead and set up the agency. And it did absolutely wonderful work. They did it the right way--by focusing on quality, safety, and reliability--and really set the standard. They lost it with the Challenger accident. That was a very interesting story about how that happened, how you can lose it.

The other government quality example was the Defense Department which had picked up Deming's work rather early. For example, the -- is it the Naval Air Station in Long Beach, California?—place that is famous because they used Deming's management methods in

their supply chain management and became a place people would go to study the process. So government has been a real player in this field.

Berkowitz:

Interesting. Getting back to the quality demonstration project, those hospitals were undoubtedly very used to talking to consultants, like McKinsey. What were you offering that was different from they were likely to hear from those folks?

Berwick:

The pitch was pretty simple: other industries have been able to achieve rapid and progressive improvement in products and services; health care in biotechnology has improved; our technologies get better, but our delivery hasn't.

I knew these people. They were my colleagues from my scientific work and my work at the Harvard Plan. So I would call the CEO of the hospital and say, "You want to try this?" And they would say, "Sure."

Each hospital picked a hard problem to work on. I can't remember exactly, but one of the hospitals picked billing processes. Their accounts payable was just enormous, and they couldn't crack it. Children's Hospital worked on infant transport. They had a chronic problem of going to pick up little infants at outlying hospitals; it never went smoothly. So they had a chronic problem; we brought an offer to try an interesting new tool, and no cost, it was donated services. I think it was easy to recruit the players.

We said, "You pick the problem and we'll see whether these process improvement methods that achieved so much outside healthcare could help inside healthcare." That was the premise.

Berkowitz:

I was curious when I was reading about this how much you looked into some of the earlier stuff, like industrial psychology and other things that were going on at the Harvard Business School in particular. That was a major center for this. Did you read Frederick Winslow Taylor?

Berwick:

I studied with the best in the field, and they have a very strong sense of history. The history is well-documented. The books on modern management of quality are many and wonderful. Joe Juran's masterpieces on this look both backward and forward. Juran's handbook on quality is something like 1800 pages. My colleague, Blan Godfrey, had written an award-winning textbook called "Modern Methods of Quality Control and Improvement," which has a great historical feature.

I had been prepped for this by the Kennedy School. I had read Douglas McGregor and Forrester's work on systems and general systems theory. Peter Senge's work had come out on the fifth discipline, which was also very integrative. So I knew quite a bit. Deming had not yet written his final major contribution, which he called "The Theory of Profound Knowledge," which is a terrible title, but he then organized the modern field in four categories of intellectual development: systems theory, epistemology, statistics, and

human psychology. If you take most modern -- like NASA's approach-- you'd find all four underway, each has a history. Systems theory goes way back into the 1940s or '30s, to Norbert Weiner and others.

And you have human psychology, adult learning-- John Dewey; and Chris Argyris was running great stuff at the business school. Statistics, that's back to Walter Shewhart in the 1920s; and epistemology is as far back as you can go. All of these have deep roots.

Berkowitz:

So this all seems to lead to the Institute for Health Improvement which was founded formally, I believe, in 1991? How did that come about?

Berwick:

The history there was the National Demonstration Project; the grant from Hartford had been four years long. We had run into a problem. "We" was a group of people who had started as a club. We -- these were people like me in healthcare who had learned what I'm telling you about--had begun meeting regularly and become a little bit of a friendship group. We read books together, and we became the guiding group for the Hartford Foundation project. But the problem was we didn't spend the grant.

We had started offering courses through the Harvard Community Health Plan, charging tuitions, and people would come. We had a two-year waiting list for courses. We had a large meeting, which grew fast, and charged tuition. So we ended up -- rather accidentally ended up not spending the original \$600,000 grant, and we'd save another \$600,000 of revenue over the three-year period. It was completely unplanned.

So we had something like \$800,000 to \$1.2 million, something like that, in the bank at the Harvard Plan. So in 1990, I went back to the Foundation and said, "We've got to return your grant. We didn't spend it." And they said, "No." They said, "This is a success, so we encourage you. Set up an ongoing operation; keep the money."

In fact, they gave us another grant to establish a force for change that would be nonprofit. We looked where to put it and decided to do it freestanding, and that was the Institute for Health Improvement, IHI, in 1991. At that point, I was so wrapped up in this quality movement-- I guess it was by then-- that I agreed to run the organization for six months while we looked for a CEO. I just got captivated and decided to go there.

It wasn't my full time job. I still saw kids at the Harvard Plan for another 10 years, but for something like one day a week, IHI became my major job. I also was clinical professor of pediatrics and health care policy at Harvard Medical School and professor of healthcare management at Harvard School of Public Health, so I had some ongoing teaching obligations that I continued to do. But my main job became establishing and growing IHI.

Berkowitz:

So let me ask you about that period of your life. One of the things that IHI was attempting to do was identify best practices in medicine and somehow spread them more generally. How does one go about doing something like that?

Berwick:

Well, it was an evolving story. If you come to IHI you'll see. There's a diagram there that shows the evolution; it was a completely dynamic evolution.

The strategy of IHI has been relatively stable. It was a four-part strategy. It's got a core of innovation and research, so that's finding a best practice or inventing one or picking a problem and trying to solve it. IHI today runs 90-day research cycles. It does five to six every 90 days, and I think it's in wave 40 or something like that. There have been close to 200 research endeavors through its history. That's the core.

The second are called strategic partnerships. These are relationships with very large organizations like the National Health Service in England or Kaiser Permanente or Ascension Health or VA. They change through time, but they're structured relationships in which anything going on in research goes out to those organizations right away. That's part of the spread plan. So KP may come to IHI and say, "we've got a problem -- flow and emergency departments," let's say. I'm making this up, but it could be one. When Ken Kizer was at the VA, he came to IHI and said, "We've got delays." There are long waiting times. He had 160 centers, and he wanted a research development relationship that would allow us to crack waiting times. So that's those strategic partnerships.

The third ring is events, courses, forums, and large-scale interactions. The fourth is the web, which has obviously gotten only better over time. So the strategy is complex with tiers.

Berkowitz:

That sounds very much like sort of a continuous process from that first endeavor to this IHI endeavor?

Berwick:

It's non-linear though, because for example, one of the rules that I try to use is feed the web first. So anything IHI learns it tries to put out free on the web, because sometimes that will generate inward flow of information. Strategic partnerships can create research projects. It's all a dynamic, as I say.

There have been phases in the evolution. I don't remember them all. The first one is education. The first two or three years the main thing it did was teach people, thousands of people. Then it added in collaborative improvement--that was the breakthrough series in 1996. The next was innovation. That's where the research engine came from. The next phase was going to scale. That's where the 100,000 Lives campaign came in 2004. We had six changes we knew save lives. We wanted to bring them everywhere. The next phase was Build a Movement. That had a little, almost political, edge, trying to generate a public agenda for change. I left then. That's when I went to CMS, but it continued, and I think it's currently in population health. It's moved very big into population health now, so this has been a developing story.

Berkowitz:

So it's like scientific evangelism?

Berwick:

[affirmative] That's an interesting way to put it, yes.

Berkowitz:

I want to talk to you also about your work at the IOM, the Institute of Medicine, in which you've played an active role. Some of the reports that have gotten a lot of visibility are the report on, "To Err is Human", about hospital errors, and the report about quality, "Crossing the Quality Chasm." Is that something that you were involved in lobbying within IOM, to look at those issues?

Berwick:

Not lobbying--so let's see if I can remember. The initial foray into this field in force was started by David Lawrence, who was then head of Kaiser Permanente. He was a member of what was called the IOM National Roundtable on Health Care Quality. I was not a member of that at the time. I was too busy, I couldn't do it. The Roundtable on Quality-- it was 1997 or so, '96 or '97--generated a recommendation to the IOM. It recommended that IOM on its own initiative, not through Congressional requests, set up a committee on quality of care in America. That report, the Roundtable report, famously said, "The chassis is broken." That was David Lawrence's comment.

At the same time, at that point, I was serving for President Clinton on the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. It was chaired by Donna Shalala and the Secretary of Labor, Alexis Herman. The two Secretaries chaired. It was a 20, 22-member committee, and it was also producing a report on the state of play, which was fully informed by RAND, by the way. We had the RAND Health Insurance Experiment and the Medical Outcome Study-- generative studies. That report came out in about '98, I think. But it also pushed toward concerns. It was started because of concerns about managed care, but this report said no, it's not managed care. The quality issues are pervasive. The third thing that happened -- few people remember this--was a report on cancer care in America. It was from the IOM, the National Cancer Policy Board, and it was a pretty concerning set of comments on cancer care in the country. All of this was in '97, '98. It was a coming together of concerns.

So the IOM proceeded. It set up its own committee on quality care in America in 1998, it must have been. I was on it, and we began our work. It was chaired by Bill Richardson, who was then head of the Kellogg Foundation. And we had terrific staff support with Janet Corrigan leading it. We decided to focus first on patient safety, which was emerging as an area of concern due to Lucien Leap's writings. It was a deep area of concern to me. I'd studied it with Lucien and others. And that led to the report, "To Err is Human," in 1999, which was a real shot across the bow. That's where we estimated 44,000 to 98,000 deaths a year, depending on whether we extrapolated from the Colorado/Utah study or the New York State study and the Harvard Medical Practice study in New York State.

It was headline news. There's a funny story behind that. It was a Monday morning headline, and the report leaked. It was supposed to come out on Wednesday, but it leaked on Sunday, and Lucien and I got calls from the IOM to get down to Washington as fast as we could because they decided to accelerate release of the report. And we did. I flew

down here. And that Monday we spent our time traveling around the city to radio stations and TV stations. There was a phenomenal interest in a problem that had been under the table for a long time.

That Wednesday turned out to be the Wednesday in which the World Trade Organization had met in Seattle. There were protests in the street and that grabbed the headlines on Wednesday. I always have thought that if that report had been released on schedule on Wednesday, it would have been page 6, no one would have seen it, and the quality movement would have missed its debut.

Berkowitz:

Serendipity often takes hold of these things.

Berwick:

Yes, that's true.

We went on to write the second report from that Committee, which was called "Crossing the Quality Chasm," which appeared in 2001. I had a major opportunity to help with that. The Committee is divided into two groups, one group on the environment and one group on the chassis, as in "The chassis is broken." I chaired the chassis committee. And out of that committee, I remember the meeting -- I remember writing down -- I said to the group, "We're going to be doing redesign, but you can't do redesign without aims, and we got to figure out what we're trying to get done with healthcare." And I wrote down "safe, effective, patient-controlled, timely, efficient, equitable." I said, "I think these are the goals." And they said, "No, no, patient control is too strong," and so we got to "patient-centered." That was the key moment at which we began to articulate goals. It was a phenomenal experience. You may know in that report are the ten principles for redesign of care, and that came out of general systems theory from complex adaptive systems. We wrote down these ten rules of redesign.

Berkowitz:

The IOM has always been interested in influencing medical practice which is hard to do. This report proved very much a success for them?

Berwick:

It was the right message at the right time. Everything came together. The science was ready; public concern was available; there was good leadership at the IOM, courageous leadership; a committee that really did its job. It was a very important experience.

Berkowitz:

So let me turn to the Centers for Medicare and Medicaid Services and your experience with that. It's clear that the process of appointing a CMS administrator had been politically fraught for many years. They had a great deal of difficulty getting somebody in place, past the Senate. I wondered if you could just talk about that. This was around the passage of the Affordable Care Act; I believe you were nominated on April 29, 2010. Could you describe that? Who talked to you at the White House? How did it come about?

Berwick:

I'm sure there's a story behind it all that I don't know. My end of it was that I actually was called in December of 2008 after the election.

I was at my home in New Hampshire; I have a vacation home there. Senator Daschle called--Tom Daschle. He at that time was the designee to become Secretary of HHS. I had met him once. I'd given him a memorandum during the campaign about what I thought would be possible in redesigning the government's approach to making healthcare better. I actually wrote it with Atul Gawande. Atul couldn't go so I went down and met with Daschle. That was my one meeting with him.

I don't know what really prompted the call to me. You'd have to ask him. He's since become a friend, but I haven't asked him what was going on. That was probably August maybe. In December he called me and asked if I would agree to run CMS. I'd never thought about it; it had never crossed my mind. I had no intention of going into government. I was perfectly happy at IHI. And I said, "No."

Berkowitz:

To be clear; this is December after the election, a month after the election?

Berwick:

It was right after the election. Obama was President-Elect. Daschle was everyone's bet to be HHS Secretary, and he called me. I turned it down. I remember saying to him, "Senator, it's an enormous insurance company. You don't want me to run CMS." He said, "You're absolutely, right, Don. I don't want you to run CMS. I want you to change CMS." That was his pitch. I didn't flat turn it down. I said I didn't think it was such a good idea, thought about it, and I ended up flying down. I met with Tom and with a group of his advisors, and that began a long thought process for me and many, many nights of deep conversation with my wife, who is a public official. She had just finished being chair of the Public Utilities Committee in Massachusetts. At the time, I believe she was or was going to become the Undersecretary for Energy in Massachusetts. So she couldn't move. We knew that. We'd been married for over 30 years, and it was a very difficult decision process. But I thought and thought and thought, and then I had multiple conversations, including many with Jeanne Lambrew who by then clearly was going to be key. And to make a long story short, by February, 2009, I changed my mind.

So I said yes. The process of nomination then began, vetting began: the FBI investigation, ethics forums, answering the Senate Finance Committee questionnaire-- hours and hours and hours. And then you may remember Senator Daschle did not get appointed. He withdrew his nomination. And it was unclear then who would be Secretary, and everything was suspended.

I don't remember the exact sequence here, but I went to Washington and spoke with the Administration officials at that point and said, "I don't know who's going to be Secretary. Is it proper for me to just accept the job without the boss, my boss, saying he or she wanted me?" At that point the White House said, "In that case, we're back to square one, because you could have the job now if you want it, but if you are saying you want to decide based on who actually comes in, it's not wired that you're not going to have to reapply, as it were."

I said, "Well, that's the nature of the situation." I didn't want to take the job without knowing that the person in the Secretary's office wanted me. That then was followed by a long period, and then finally, Secretary Sebelius was nominated.

Berkowitz:

Did you know her?

Berwick:

She was a member of the President's Advisory Commission under Clinton that I served on. So I knew her from then.

At that point, everything stopped, because I guess the Affordable Care Act was in the works, and they didn't want to screw up the difficult process of getting that law passed with also processing a nomination, so it was a long period of silence. That brought us to September 2009, at which point I got back in touch with the Administration. They said, "We hope you're calling about the CMS job." I said, "Yes, I am." So they said, "Get down here now." So I came down a couple of days later and met with Secretary Sebelius and she offered me the job on the spot. That was September 2009.

Then again, complete silence. Everything got shut down. No nomination was put forward during the negotiation of the Affordable Care Act. That brings things to March (2010) when the Affordable Care Act passed. And I then went through all of the vetting again, all the forms to make sure I was still acceptable. And the hope, my hope at that time was that my nomination would then go forward to the Senate for confirmation. Now, that did not happen. In July, during the July 4th vacation in 2010, the White House called and said-- I guess it was the Secretary who called--, "The President wants to proceed with a recess appointment," which is not an acting appointment. A recess appointment entails full power. The Acting Administrator at that time was Marilyn Tavenner.

I had three days' notice to get down there, was sworn in Boston.

Berkowitz:

A recess appointment is something that is unusual for this particular job. Was that a complicated political decision?

Berwick:

It was not mine, it was the President's. I don't know how they reached it, but they reached it. They needed someone in office. They only had an Acting Administrator. An Acting doesn't have full powers, and they knew they needed someone to begin the implementation of the Affordable Care Act.

I don't really know; I'm guessing. I have no real idea what was going on, the White House end of it. All I know is I got a call saying "Get down here."

Berkowitz:

From Secretary Sebelius?

Berwick:

Well, that call wasn't from her, but she had called me before to explain the process to me.

Berkowitz:

When you say the White House, called, was there someone in particular?

Berwick:

Well, there's Personnel Management. There are people who shepherd the nomination process through.

Berkowitz:

They must have asked you questions about your relationship to the Massachusetts Congressional delegation as well?

Berwick:

No, never.

Berkowitz:

They didn't ask you if you knew Senator Kerry or others?

Berwick:

No, I don't remember being asked that in the whole process.

Berkowitz:

And so in many ways this is really a merit nomination in the sense that you had the expertise to begin to implement this with some eye to bending the cost curve, improving quality. You seemed to be an ideal person to do that?

Berwick:

Obviously, there were people in the Senate who didn't think so, but I thought it was an opportunity of a lifetime. I thought, here was the moment in America when a combination of healthcare as a human right--or at least steps towards that--and a chance to make care what it could be for people was at hand. So I thought it was an amazing opportunity.

Berkowitz:

I've heard this expression "the Triple Aim," can you talk about that?

Berwick:

Yes. In 2008, maybe, I published an article in *Health Affairs* called "The Triple Aim." The concept is often attributed to me, but it shouldn't be. The concept of the Triple Aim came from two colleagues of mine at IHI, two faculty members there, Dr. John Whittington, who is an internist in Peoria, Illinois and was on the IHI faculty, and a statistician in Washington named Tom Nolan, who was a protégé of W. Edwards Deming's.

Whittington and Nolan had written a memorandum to me as CEO of IHI and to the organization about the IOM report that talked about the aim of healthcare being safe, effective, patient-centered, timely, efficient, equitable care; I had frankly written that, and they were saying it weren't sufficient. The IOM report was talking about better care, but quality is meeting need. That's the definition of quality, meeting need.

So the question is: what is the need?

They said there are really three things, not one. Better care is one. That's the six aims talked about in the IOM report. The second is, don't get sick in the first place. There should be an enterprise to keep people well, because environmental factors, exercise, nutrition, poverty, air pollution, they're 400 percent more powerful in determining health than healthcare is. They felt, and they were correct, that the second aim of improving health of populations should be in the aim set. And the third was reducing per capita costs, because it was clear, we were shifting social resources, public and private resources to healthcare that were needed in other sectors. So they said "better care, better health, lower costs." That's the aim set.

I wrote that paper, I think it was 2008, in *Health Affairs*, and when I was asked to go to CMS, one of my thoughts was here's a chance to use the largest purchasing influence in the nation--in the world-- to begin to shape the healthcare enterprise toward real health and well-being as well as excellence and proper frugality, stewardship of resources, better care, better health, lower costs. When I went to CMS, that was very much on my mind. I also knew the methodologies, because I'd spent 30 years working on how to make things better, and I thought a payer could provide incentives and resources to healthcare delivery to actually change what it does. You don't get that free, you have to invest in change. So I got quite excited about the potential under the Affordable Care Act, especially because the Affordable Care Act had tools, the best of which was CMMI, The Center for Medicare and Medicaid Innovation. There was \$10 billion in the Affordable Care Act set aside to support innovation, which is one of the crucial components of a total quality system. So, I thought the opportunity was extraordinary.

Berkowitz:

When I became the chairman of my small department in academia, I faced a learning curve. When you became the head of the largest health financing enterprise in the world, that must've been a pretty steep learning curve, too?

Berwick:

Oh, yes, it certainly was. It was absolutely amazing. It's a wonderful organization in many ways. Before I went, people pulled me aside, said, "Why are you doing this? You'll be eaten alive by the bureaucracy." They painted a picture of a kind of mindless beast, an enormous, hungry system. What I found there was exactly the opposite. The minute I arrived there, I was helped. The staff, the Senior Executive Service, the people who reported to me—it was almost like they surrounded me to help me. I was put through college basically. I was given briefing books, hundreds and hundreds of pages, extremely well organized, issue by issue, component by component. There was a briefing book on CMS and a briefing book on the Affordable Care Act. And I wasn't left alone with them. I would literally take a section on CHIP or Medicaid or Survey and Certification, or the payment regulations, and be walked through it by people who really were the experts. The staff would meet with me and walk me through it.

The White House was wonderful on briefings. We had many sessions where people from the White House would come to HSS, sit in the Secretary's conference room with me and

push me through issues that were hot, that I needed to deal with, or that I might have to deal with. I've never, ever in my life received more support for learning.

I knew quality, I knew delivery, I knew a lot about healthcare. I knew health services research cold, I taught it. But the intricacies of a hospital payment rule, or the Affordable Care Act--I had to be taught that, and it was marvelous. I was jumping on a moving ship, so the minute I arrived, began working on these things day after day. Things were organized in what they call issue meetings. An issue meeting would be from one of the divisions-- program Integrity or Medicare or Medicaid, for example. On Tuesday at 10:00 they'd come in for the issues of the week. Here's a regulation, you're going to sign this regulation or not; here's an NPRM, Notice of Proposed Rulemaking, or sub-regulatory guidance, or a state plan amendment decisions for Medicaid, these were all coming at me, so I had to be briefed, not only in the big picture but also on each of these.

It was absolutely wonderful. But I had a compass. I knew how I wanted to run the place; I knew how I wanted to do it. And people were pretty generous about that. I had, after all, taught and managed quality in my own organization, and globally for three decades, and I knew the clock was ticking. The recess appointment, I knew lasted 17 months, that was it.

Berkowitz:

We should point out, that a recess appointment is only good for that Congress, essentially.

Berwick:

At the Supreme Court they don't seem to think it's good at all now. Yes, it's good for that, the year you're appointed and the subsequent calendar year. So for me, I arrived in July of 2010. I knew that the clock was ticking toward December 2011, unless the President could get me confirmed. At that time, I think they thought that he might get me confirmed. The midterms had not happened; we were just a couple of votes shy.

Berkowitz:

The ACA was already passed?

Berwick:

The ACA was passed. It was a moment of hope for reconciliation as to the Secretary and I; she said that to me, and I hoped. But I didn't bet on that. I thought 17 months was a good time window. So on day three, I had an all staff meeting. I pulled everyone together, 5,500 people--1,200 in an auditorium in Baltimore, everyone on their screens. And I just introduced myself. I showed a picture of my family. I'd written by then a new mission statement for the agency. I said, "All right, this is what I think it is." I asked my senior staff to correct it, but it said, "We'll be a major force and a trustworthy partner for the continual improvement of health and healthcare for all Americans." I said, "You may think of yourselves as payers, cutting checks. But we're a major force for the improvement of care. It's not just for Medicare and Medicaid, because if we act, everyone follows. So we're going to improve healthcare for all Americans." I said, "It doesn't matter where you work, what department you're in, I don't care if you're serving food in the cafeteria, we're going to change care for all Americans." And I said that "by that I mean the Triple Aim." And I put up the Triple Aim. The General Counsel did not allow me to use the phrase Triple Aim because it came from IHI, so we called it the Three-Part Aim.

Berkowitz:

It was trademarked or something?

Berwick:

No, it wasn't trademarked. They just were worried about I guess the potential for the accusation that it would somehow redound to IHI's benefit, which wasn't an issue, because it wasn't trademarked.

I laid it out; I explained the three part aim. I laid out values. The theory I work with is that the main thing an executive does in an organization is articulate and support what I call operating values. This is how we'll work together, and I picked five.

First was "boundarylessness," which is we're going to start to tear down the walls. I said, "I don't know if you can do this, but if you can, go work in another department for a half day." Boundarylessness then "speed and agility" which means we're going to have to move really fast, because the world is changing fast. Next is "unconditional teamwork," which meant, "You've seen the budget; you know our budget is going to get cut. We had \$1 billion to implement the Affordable Care Act for two years, one billion. It should have been \$8 billion. We're going to have to share, so unconditional teamwork is the new rule."

The fourth is "Innovation," which is a new expectation that will constantly change our work. We'll do to ourselves what we want healthcare to do. We want healthcare to change, we'll change. So figure out an idea that you think is better, and pursue it, and if you fail, that's good, because that's how we'll learn.

And then "customer focused" was the fifth value. "Customer focused" meant we're going to start listening, so I said, "Go out to the hospitals, go out to the doctors, go out to the regions, figure out what they need from you, because your excellence is in their eyes only."

I linked the SES, Senior Executive Service, Compensation scheme to those five values. I said "from now on your variable compensation doesn't depend on your productivity, it depends on the values." I began training. I scheduled -- over time -- four 90-minute training sessions. I said, "I'll train you on quality. I've taught it for 30 years. I'll teach you."

I opened that up to all 5,000 people. I taught the class, but we recorded it so everyone could take the class. I wrote a new strategy with my staff with 19 goals, and then I put it on the web. I said "anybody in the organization can comment." We opened a mailbox and we had, as I recall it, about 290 comments come in from everyone who wanted to critique the strategy. That's called Hoshin Kanri. It's a Japanese strategy approach, but very open. And then I traveled. I visited every region. It took me a year to do it, but I was the first administrator, they told me, in 10 years to visit every region. I walked to the corridors in Baltimore and I shook every hand.

Berkowitz:

That alone is a big project, walking the corridors.

Berwick:

Oh, man. It took me six months to get through it, and I never made the night shift. That always bothered me. I wanted to go back to the night shift, but I didn't. This was all quality management. I was trying to use everything I knew about quality, including measurements, because for all of the 19 goals, I had a metric for tracking them.

Berkowitz:

It reminds a little bit of John Gardner, when he was the head of Health, Education, and Welfare. He was, similarly, an inspirational kind of a leader.

Your decision not to serve beyond December 2011, the end of your appointment, was that sort of obvious to you?

Berwick:

It wasn't a decision. It was a legal requirement. I had to leave. The constitutional provision ran out. I think -- I'm not sure -- I think the White House wanted me to stay if they could. They tried every avenue they could think of. And no one ever was able to come up with a way for me to stay.

I wanted to stay, but it wasn't possible. I left. I think technically the appointment ends when Congress recesses or adjourns in December. They hadn't adjourned. They were probably two weeks from adjournment, but at that point, hanging on the last two weeks, it didn't make sense for my family or for me, so I resigned on December 2, but I had no choice. I desperately wish I could have stayed. It was the best job I ever had. It's the best job in America, probably the best job in healthcare in the world.

Berkowitz:

One could say that this kind of work seems to have taken with you, judging by the fact that you ran for Governor of Massachusetts in the summer of 2013. Is there continuity there?

Berwick:

Yes, there is. I'd never been in government. My wife was in state government. I saw the good; I saw what government can do.

At CMS I could do things. I remember moments as administrator when I just had to pinch myself that I was getting to do something good for people. I could never ever, ever do that elsewhere at that scale. There was a very positive piece to that, and so I really wanted to stay in government if I could. I couldn't do it here in Washington. Orrin Hatch, I guess, had organized a letter; 42 senators signed the letter, saying that I shouldn't stay, and once that was there, we knew the game was up. It kind of poisoned the well here, at least for a while. But I wanted to stay.

I could have run for the legislature, but I think I'm more an executive, and the governorship was coming open. It seemed the right skills. Six, seven million people live in Massachusetts. That's a good size to try to work with. The other part of it was, I was, and I am, distressed about the direction of government as a trusted agent for our futures. And I think government's got to really be effective. It's got to earn public trust. And more than that, proper management of the well-being of communities requires a kind of cross-functional thinking. In the case of health, its health in all policies. It means education and

transport and environment have almost as much to do with health as healthcare, so you've got to think comprehensively. I think even beyond health, you worry about the well-being of children or the vitality of elders or the future. You've got to think cross-functionally.

And I'm a cross-functional manager. So I thought I could actually help create the kind of interactions that we need. As CMS administrator, I was able to do it. The minute I got there, I went to the Secretary, who was emphasizing teamwork from the start. Secretary Sebelius constantly said, "We're one team. We need to act that way." So I got in touch with Francis Collins, at NIH, Mary Wakefield at HRSA, Tom Frieden at CDC. In each case we began trying to craft a whole different level of cooperative activity. Out of the CDC came the "One Million Hearts Campaign." With Dr. Collins, we started a wonderful series of meetings involving the top team at CMS and the top team at NIH. We met probably three or four times for dinner, talking about cooperation -- what does NIH know that could help CMS be more effective? And what does CMS know that could help contribute to NIH? It was so generative. I thought as Governor I could do that across big sectors. So it was all attractive. And then I looked at the politics, I thought, I've got a shot.

Berkowitz:

And you did quite well.

Berwick:

Yes, I got 22 percent of the primary vote. I wish it would have been 51 percent, but I thought it was a great opportunity and, as a campaign, I was right. People want that. The public wants it. They want effective government. They want people to work together. They're tired of things feeling stuck. And the needs are enormous. We still have poverty and homelessness and tremendous problems that we ought to be doing better with, so that was my story there.

Berkowitz:

And so that leaves you with lots to do. That's a good note on which to end. Thank you so much.

Berwick:

My pleasure.

Interview with Earl (Duke) Collier, Jr.

Washington, DC on July 22, 2015

Interviewed by Edward Berkowitz

Transcript edited for clarity.

Berkowitz:

Today is Wednesday, July 22nd, and I am talking with Earl Collier, Jr. You like to be called Duke?

Collier:

I do.

Berkowitz:

You are in Massachusetts. Do I have that right?

Collier:

I'm sitting in Boston.

Berkowitz:

I want to ask you about yourself a bit, biographical details, and I want to talk about your time at HCFA and then maybe talk about your considerable time after that in the healthcare industry.

I know a little bit about you: that you went to college at Yale; you're from New England; your father worked for the phone company, but I wonder if maybe you can talk a little more about just your childhood leading up to going to Yale.

Collier:

Sure. I actually grew up in Richmond, Virginia. I only moved to Boston late in the '90s after a long time in and around D.C., but I grew up in Richmond, and it was an interesting time. It was the middle of civil rights, and one was quite aware of that.

I was fortunate in my parents in the sense that I wasn't infected with some of the southern attitudes that were around. When I went up to Yale, I ended up majoring in political science, and I had two areas of interest. One was southern history and politics, and the other was urban studies. Yale was just a coincidence, which I could bore you with, but I won't, other than to say, I was a scholarship student in a private school by the time I graduated. There were 35 boys in the class and 35 girls, and 10 of the boys went to UVA (the University of Virginia). I think all but three stayed somewhere in the south, so off I went; then I came back to Virginia for law school, of course. And then to D.C.

Berkowitz:

But Yale, you were the class of 1970?

Collier:

'69.

Berkowitz:

'69. So do you have the stories about -- were Brian Dowling, Gary Trudeau and George Bush around at the time?

Collier:

[laughs] Yes, all three highly visible, and I didn't know any of them personally, but they were highly visible, and Doonesbury had begun then. Trudeau was a year behind me. Bush was a year ahead, and Dowling was in my class.

Yale, for a person like me, was eye opening and, in some ways, complicated. I was widely derided for having a southern accent and made many friends there, but I often felt like kind of outsider [laughs], so I think it was probably a healthy thing to have done.

Berkowitz:

[affirmative] I see. So the other question that comes to mind in that Kingman Brewster era is related to the student activism at Yale. Did you consider yourself part of that?

Collier:

No. You know, it's interesting, the class of '69 was the last class admitted by the then dean of admissions; his name I'm blanking on.

And his successor, starting with the class of '70, had a highly different philosophy, so our class was the last of the so-called "well-rounded" people. You can put that in quotes or something. The next guy wanted people who had really conspicuously interesting traits or skills. It was remarked at the time that our class was full of very interesting people, and there was a lot of, I think, interest in social activities and so on, but the next class, the class of '70, was much more aggressively full of student activists.

It was also the first time women were at Yale. Mine was the last year in which there were no women at Yale, so those two features starting with the class of '70, I think, made it quite distinct and, in many ways, a much more interesting class just because of the times and its makeup.

Berkowitz:

It was also the time when Yale was getting more people from public schools rather than private schools.

Collier:

That's right.

And I was in essence a public school kid. I had finished up at private school only because my public elementary school teacher and principal had become the headmaster of this school and kept offering me scholarships to come, and finally, I was tempted, but I was a classic public school kid.

Berkowitz:

So after you went to Yale, you went to on to law school at the University of Virginia, which was sort of like coming home for you?

Collier:

In many ways, yes it was. It was a comfortable choice. From an academic point of view, I was a “waiting list at Harvard” kind of guy and I am not even sure I made the waiting list at Yale, which was a smaller school. So I was going to be in the Virginia class of schools, and in that group, that was the most comfortable one. Although, at that time, the university as a whole was taking only about half its students from instate, and the law school was heavily weighted to out-of-state kids, although many had gone to UVA undergraduate.

Berkowitz:

Was there a moment in your undergraduate career where you said, “Oh yes, I’m going to go to law school,” or was it one of those decisions where the preponderance of evidence was to go to law school, but it wasn’t so obvious?

Collier:

[laughs] I think there were probably two things. I remember one was being told as a kid that I argued so much I should be a lawyer. The other thing was I knew nothing about what I wanted to do after I got out of school, but I was interested in politics and history and so forth. I knew nothing about medicine. I knew nothing about business, and so law school was one of those things where everyone would say, “Well, you can keep your options open.” In some ways it was just to serve as a temporizing thing, but it turned out to be a good choice for me. It was a good kind of education for me, so I was glad I did it.

Berkowitz:

So after you graduated from the law school, you did a clerkship, which was traditional I believe, but you then worked for Covington & Burling?

Collier:

Yes. In those days, clerking, as you say, was pretty conventional, and going to a large, general practice law firm was also sort of the conventional thing. If you knew you wanted to be a litigator, often you would go to the Department of Justice or to an Attorney General’s Office, but most people who didn’t know what they wanted to do would go to a big firm because, again, you could keep your options open; you can try this, try that.

Berkowitz:

Right. I think of Covington & Burling as one of the really top-line law firms. Is that because of my Washington location?

Collier:

Covington, at the time, yes, it was pretty amusing. There had been a book written somewhere right in there called “The Super Lawyers,” which had a little currency in D.C. It was talking about what we have all come to understand in terms of what Washington law firms could be, but it featured Covington, which was, at the time, the largest firm in Washington.

Yes, it was a great firm. I had been a student assistant to and mentored by a guy at Virginia named Dick Merrill, and he, in turn, had been an associate at Covington before he came to teach. His mentor at Covington and thereafter was a guy named Peter Hutt, and they both knew a lot about FDA stuff. So, as I was thinking about what firm to choose, I was heavily influenced by Dick and Peter and by their thoughts about Covington. I knew I wanted to do some kind of regulatory stuff, continuing my academic interest because I liked that intersection of law and public policy. Covington had a big practice in that area. I actually started with part of my time in the food and drug area, although that transitioned.

Berkowitz:

So it sounds to me like it made sense for you to be in Washington, as opposed to -- I don't know -- Wall Street or Chicago or Los Angeles?

Collier:

Yes. I would not have had anything to do in those places. I never knew anything about business and didn't have much interest in it, frankly.

Berkowitz:

So we come now to the political part of your career. You got this job at HCFA in the Carter administration at a very young age. Did you work for the Carter campaign in 1976?

Collier:

No, I didn't. I did not know a lot about that kind of stuff. I was just practicing law as a kid, young lawyer, but I had a lot of interest in law and public policy. So, as part of a rotation that Covington sponsored, I did six months at Legal Services and had some work with Medicaid there, mostly on behalf of potential or wannabe or disgruntled beneficiaries, as well as some other stuff. As a result of that, I asked if I could get on the team of a guy named Chuck Miller, who had developed a practice in which he represented states against the federal government. He had a heyday with that because the Nixon administration had done a lot of cutting off of block grants, so that there were a lot of social service programs, Title 20, and programs like that, where the block grants had been cut. The states were suing, and so he did a lot of work for the states.

He didn't have any room for me in any of those cases, but somewhere around 1977-- I had been there about three years and I was back from Legal Services--the State of New York, which had been our client for other things, hired Covington to defend it in a lawsuit that the Hospital Association had brought, challenging New York's pioneering prospective payment system. It became kind of the defining case with respect to the legality of prospective payment under the laws governing Medicaid. So I got on that case and I really enjoyed it -- it just brought everything together that I liked.

I found myself really liking the state people [laughs] for one thing, but also I liked Medicaid. I found that I like medicine and science; and healthcare policy was a quintessential intersection of government and private activity. You are regulating hospitals; you are paying hospitals; you are overseeing the quality of their work; it includes nursing homes and other providers as well. For me, it was wonderful. One result of that lawsuit was that the state reorganized its health department to be a little bit more sophisticated about the things they were trying to do in cost containment and regulation. I had become close to

the state people by then, so I got a job as the number two person in what they named the Office of Health Systems Management, and I moved to Albany.

Berkowitz:

You left Covington to do that?

Collier:

That's what I did. I was given an offer, and I went up. I moved to Albany. This was in the (Hugh) Carey administration. I spent two years there, and I loved it because I also got to see politics at the state level. It was really my first exposure to retail politics and to the sausage-making process because at Covington, I had been more of a big-case guy, a litigation guy.

Somewhere in there, we had a lot of interaction with what were then called PSROs (Professional Services Review Organizations). We were having a lot of discussions with the PSROs and with the Feds. There was a lot of angst between them, and we were sort of moderating in between. I had gotten to know very well a woman named Helen Smits, who was HCFA's Director of the Health Standards and Quality Bureau-- head of all the stuff into which PSRO's and related things fit. She is a doc, very smart, a very nice person. So when Califano fired Derzon and moved Leonard (Schaeffer) over to be the Administrator, he was starting to meet people he might want to recruit. Helen Smits introduced me to him, and that led to my getting to know Schaeffer quite a bit. At a certain point, he started offering me jobs, and I was not interested in any of them until he finally offered me the Deputy Administrator job, which did seem like it was worth taking, so then I moved back.

Berkowitz:

It seems to me Califano, at the time, was big on having lawyers around. There were quite a few high-powered, young lawyers around him.

Collier:

Yes. Well, he was himself a high-powered lawyer.

Berkowitz:

He was, by definition.

Collier:

Yes, and it was a way of thinking, of problem analysis, and problem solving that was very comfortable for him. But I think I had been there less than a month when Califano got fired. Califano and I overlapped by about a month maybe.

Berkowitz:

And then Patricia Harris took over?

Collier:

Then Pat Harris took over. That's right.

Berkowitz:

Were you a Democrat?

Collier:

Oh yes. I was and am.

Berkowitz:

I guess a lot of people from Virginia were Democrats at the time.

Collier:

That's what you were in those days. If you were a Democrat in those days, you would be a Republican now, but I actually was a real Democrat by contemporary standards.

Berkowitz:

So your approach then to the Carter administration was from the HEW side and from the HCFA side rather than from the White House. Was your position a presidential appointment?

Collier:

Yes. In fact, I left on the day of the Reagan inaugural, so it was a very political appointment.

Berkowitz:

At HCFA, what was your job about; was it running the day to day or did you specialize?

Collier:

Well, it was interesting. It turned out, of course, I knew a lot about Medicaid. And, as a result of that, I knew a lot about long-term care. The place in which I sat in New York regulated nursing homes and reimbursed them, and there had been constant litigation about quality problems in the nursing homes, about fraud and abuse in the nursing homes. A lot of the anti-fraud and abuse work had really been originated by a Brooklyn prosecutor, Charles Hynes, prosecuting New York State nursing homes in the '70s. I knew a lot about all that stuff, and that meant I ended up spending a lot of time on that. I spent a lot of time on long-term care and how Medicare and Medicaid should pay for that and think about it. And I knew a lot about hospital regulation, so I was relatively comfortable in some aspects of working on the Hill.

And I was very comfortable working with people from the AHA (the American Hospital Association) or people from hospitals because it was just a world I had come to know very well, and Leonard did not have that background. He was really a state budget guy who had become a brilliant management and budget-type guy. That was his strength, and that was what he drifted towards; he was not as comfortable with a lot of the policy stuff. By then, I had spent a lot of time on policy things, between the New York lawsuit and my New York work, so it actually divided in an odd way. He was much more interested in the operations, and I was more interested in the policy. He and Harris did not get along either. It was sort of an almost instant dislike. So I became the guy who got sent to a lot of meetings that the Secretary was having. If he felt he could get away with not going, he would send me.

Berkowitz:

Was Schaeffer considered kind of a whiz-kid type, such as Califano would have seen when he was in the Department of Defense? What do you think was the conflict between Schaefer and Harris?

Collier:

Well, if you look at Harris--who I really came to like, personally--she was a person who had achieved much, but, at some level, was pretty insecure.

Berkowitz:

[affirmative]

Collier:

For example, she had this habit --at every large meeting I was in with her, she would start with some kind of aggressive, personal behavior. A famous one was this: she starts the meeting and says "I have here in front of me this memorandum, which has been extremely difficult for me to use because there are no numbers on the pages."

Berkowitz:

[laughs]

Collier:

She would sit at the middle of the conference table, a very long conference table, and the other person who led the meeting would be on the other side. She was staring right at the person across the table, and she would work very hard to intimidate whoever that person was in whatever way, and she was pretty good at it. Then after that, everything would calm down, and the meeting would head on off. Plus, she tended to like a certain kind of person, and Leonard was not that person.

You spend a lot of time with Leonard, I assume, based on the work you are doing. So you know he is who he is. He's very smart, very capable, very in your face. So [laughs] I got along pretty well with him, but I also got along well with Harris. I was the bargain that they struck to do a lot of the stuff, but it was good for me. I got a little more time in some settings than I might otherwise have done.

Berkowitz:

You knew a lot about Medicaid, and New York was always used as an example of a lavish Medicaid state. Were you the inside guy on that for HCFA?

Collier:

Well, I certainly was the guy that knew the most about it, and I was very at ease with people from state governments, and I was very at ease with people from complicated state governments like New York and specifically with New York. So yes, that was not an uncommon area for me to deal with.

But a lot of the troublesome issues in those days had to do with trying to get a grip on Medicare costs. The states were all doing their different kinds of experiments. The ones who were at the front--California, New York, and Massachusetts--were all playing off each

other. We were trying to be helpful and encouraging about experiments, but a lot of the action was around Medicare costs and attempts to contain it and to manage it better.

Berkowitz:

I think of New Jersey also as an important state in developing experiments.

Collier:

Yes, and Maryland also. People had been writing about the need for cost containment, starting almost from the time when Medicare and Medicaid passed, and there was a ferocious amount of activity by the mid-'70s. New York was quite visibly about to go broke, so took an aggressive approach to reducing hospital Medicaid payments via prospective payment. Meanwhile the Yale group's work on groupers and DRGs was maturing, and became a focus both at HCFA and in many states as a possible approach to prospective payment.

Berkowitz:

Well, that's interesting. You are saying that HCFA was sympathetic to that?

Collier:

Entirely sympathetic, yes, everybody was; there was no question anymore about whether you needed to contain the cost of Medicare. The question was, "How are we going to do it?" The most promising ideas were the experiments the states were undertaking with state costs: prospective payment and certificate-of-need regulations and stuff like that. But the real focus was on prospective payment.

Berkowitz:

Speaking of cost containment, another Carter era thing is the hospital cost containment legislation he tried to pass; were you involved in that at all?

Collier:

Sure. Yes.

Berkowitz:

What kind of work would you do for that? I think of that somehow as a White House initiative rather than a HCFA initiative, but maybe I'm wrong about that.

Collier:

Well, Leonard -- unlike Harris -- had a pretty good relationship with some of the guys at the White House. At least in those days, there was no attempt to sideline HCFA in working on stuff like that. The policy people at HCFA and the researchers there--a lot of the ideas were coming out of their work and their thinking, and the network of academic foundation people that they were working with. OMB was fascinated by this and fascinated by how you could save costs on administration of Medicare. The heart of thinking about hospital cost containment was coming out of HCFA. So once Harris was there, there was no friction with the White House. There had been a fair amount of friction with Califano, obviously.

Berkowitz:

So, now, you had a period where you were acting head of HCFA; is that right?

Collier:

Yes, but that was extremely nominal.

Harris finally couldn't stand it anymore, so she fired Leonard. She called me in and said, "I want you to be the acting head, but you're still sort of a kid, so, nothing personal, but you're not going to be my head of HCFA."

She did a little search and brought in Howard Newman. I can't remember the exact timing, but I was an insignificant head [laughs]. Newman and I got along okay, more or less okay. He was not exactly my kind of guy. I was much more a Leonard kind of guy, but I ended up staying till the end. Once the election was done, I was ready to roll, but decided I would stay because it was going to be kind of an awful transition, and I was sympathetic to my civil service colleagues, so I stayed to help them until the inauguration.

Berkowitz:

In modern times, a lot of these acting heads are people who couldn't get confirmed by the Senate, but I guess in your case, it really was just an interim kind of --

Collier:

Oh, yes. I would have been fine on the Hill, but I was just 31 or 32 years old. I thought of myself as capable. I thought I'd been a pretty good guy at HCFA but I had no illusions about who I was.

Berkowitz:

A lot of people after that would have stayed very directly in that health policy world and you have done that, but your course is a little bit different than many people. You went back to being a lawyer again, right, after the job at HCFA?

Collier:

Yeah, it's all I knew how to do. I talked to Hogan, and I talked to Covington. It was interesting. I wanted to build a practice by then. I thought I could do that on the reimbursement, regulatory side because there was clearly going to be some opportunity.

I talked to Chuck Miller at Covington. In the politest possible way, he said, "I don't think that's consistent with our representing states because you're going to want to represent hospitals," which turned out to be true.

Hogan was and is a nice firm and actually had offered me a job at the same time I got offered the job at Covington. I had some law school friends there, and they were building more and more specialty practices, and they were really interested in the world of health care that I knew, and they didn't have much there, but they thought it was going to be important --

Berkowitz:

At that time was Paul Rodgers, the former congressman, at Hogan & Hartson?

Collier:

That's right. Paul had gone over a couple of years before. They had some food and drug guys as well, but Paul had gone over, and he had augmented the food and drug, and then he had brought a fair amount of stuff in on the public health side. But Paul himself was not a guy who particularly knew about the more arcane aspects of reimbursement and stuff like that. He brought in some decent clients, but when I got there, he and I were better able, as a pair, to bring in work from people that he knew, work that I knew how to do, or I could at least make a credible case I could in terms of pitching people.

Berkowitz:

Right.

Collier:

So, that worked very well. In the meantime, my first day at Hogan, I'm just sort of sitting there at my empty desk, looking out the window, and I got a call from a guy I knew who was the president of the hospital association of New York State, against whom I had worked at Covington. He was on the board of Albany Medical Center, specifically on the medical school side. The medical school and the hospital were separate -- intertwined physically, but separate corporately. They were in a terrible financial distress, the medical school, and they were in a big argument with the hospital about getting paid adequately for the affiliation responsibilities for overseeing residents and interns.

That ended up being my first client. I was hired by Albany Medical College and ended up helping them work out a satisfactory arrangement with the hospital, which was, indeed, underpaying. That led to a several-year engagement in which I helped them form what is now the Albany Medical Center and brought the two places together, so that led me down the path of a fair amount of academic medical work.

Berkowitz:

So, academic medical centers become an interest for you. Have you also applied your background work in Medicare, Medicaid, and long-term care from HCFA?

Collier:

Sure. I can give you two examples. One involves hospice. I hadn't been at Hogan too long, and a couple of people -- a Methodist minister and a nurse colleague of his -- came up from Florida to see Paul Rogers. They said, "We're the founders of a hospice in Miami, and we're also part of the National Hospice Organization (NHO). We think hospice is something that everybody should know more about, and we think it should be a Medicare benefit and we'd like to engage you to help us with that."

So, Paul called me up to his office while they were there. I went up, sat down, and introduced myself, and we got talking. I had thought a lot about long term care because there were a lot of experiments in those days around trying to find more coherent ways of managing people across different settings when they had classic progressive conditions with lots of doctors and lots of settings.

I had thought a lot about that, and I'd looked at a lot of the experiments. When I was Deputy Administrator of HCFA, I served on the 1980 Under Secretary's Long-Term Care Taskforce. I was very interested in the topic.

They left, and Paul looked at me, and we just sort of laughed because this was the early days of the Reagan administration [laughs] and it was slash and burn time. But they were appealing, so we agreed to take them on, pro bono, and they turned out to be these magnificent political geniuses. They had formed something called the National Hospice Education Project. That actually became our client because the NHO didn't feel they could lobby under their C-3 designation. These guys were the leaders of that.

I got going. I was young, so I was trying to recruit people to come work for me from out of the ranks of the firm, and I didn't necessarily look like the best partnership-track guy, so I was really trying to find anybody who'd come. There was a woman, Ann Vickery, who'd worked for Bill Simon at Treasury and who'd gone to Georgetown at night and was very, very savvy politically, but for reasons that I can't reconstruct was doing trusts and estates, but somebody told me about her political background, so I recruited her to help me, and she got totally involved with it.

We ended up successfully writing the bill and getting it passed and creating hospice as a benefit. There has been something about hospice in my life, pretty much, ever since, at least avocationally. In fact, there's an interesting project going on down there now called C-TAC (Coalition to Transform Advanced Care), which is attempting to do a certain amount of modest evolution of the hospice benefit because the model of care, the team model and the way it was written -- the way the benefit was written was a perfect, scalable, modular kind of way of taking care of chronically ill people who've got lots of things going on. It's been needlessly hampered by people not wanting to admit that they're going to die and doctors not wanting to coach them to admit that they're going to die, but it works pretty well, and Tom Koutsoumpas, who, with Bill Novelli founded C-TAK, is the guy who also helped to direct in those days.

I think what happens now is some large fraction of people experience hospice and die in hospice and in general have a very, very good experience, but the average length of stay is still quite low. It's a little bit bimodal because it's easier for people to acknowledge their situations when they're in nursing homes. We wrote the benefit so that you could be taken care of with the nursing home as your home by hospice. So you get some long lengths of stay there, and on the other hand, very short lengths of stay with cancer, relatively speaking. I think people are trying to tweak that because the evolution of palliative care, the way in which palliative care is thought about, is in essence just what hospice is; it's just that now there is insistence that they acknowledge they're going to die.

That was one long term care experience. The other came through my New York experience. I knew the President of Beth Abraham Hospital up in the Bronx, which was a big nursing home with a lot of other stuff going on. He came in, and we talked about the On Lok program out in San Francisco, which I thought was a great experiment that had some visibility to it when I was at HCFA. We ended up creating on behalf of Beth Abraham, with support of RWJ (the Robert Wood Johnson Foundation) and

Commonwealth, an early version of a PACE (Program of All- Inclusive Care for the Elderly) program. I spent a good bit of time on that.

Beth Abraham had a nursing home; it had adult day care; it had home health care; it had housing, transportation, every sort of geriatric professional. The notion was that they would get paid an omnibus rate for taking complete responsibility for their patients. Just like hospice, it would be a complete payment, and they would provide everything. The idea was you could keep people more at home if you had nicely designed, interesting housing as opposed to nursing homes. You could do all kinds of things that would keep people more autonomous, healthier, coherently managed out of the hospital. But in the case of the PACE program and a number of those programs, they were based off of nursing homes. It's just been one more experiment over the years; I think maybe they did 20 of those experiments.

Berkowitz:

One of the interesting things about your career is you have this legal experience, and you have this HCFA experience, but then you also have this career with companies that do this new kind stuff such as biotechnology.

Collier:

Yes. When I went to Hogan after CMS, I didn't know anything thing about business. But I had an early client who had set up a business to do home infusion, which was made possible by the ability to use parenteral nutrition for people who have no more GI function. The physician pioneers of that, who were at places like Cleveland Clinic and various academic centers, were bringing those patients in and infusing them at the hospital, which had to be done, more or less, many times a week. One of the experts who knew about parenteral nutrition had been part of the invention of the solutions. The client envisioned a service where you could manage the patients and their infusions at home. Totally logical idea, but how should it be reimbursed? Well, if he called his regular lawyer, the regular lawyer was just a business guy, didn't know anything, and if he called a specialty healthcare lawyer, that lawyer probably knew about hospitals or maybe nursing homes. By the time he got to me, he'd burned through all the guys you normally use. So, in that case, I became a student of young venture-funded entrepreneurial companies.

The only things that got to me were things that were somewhat novel, and therefore, nobody knew about them. So that meant new kinds of services, like home infusion therapy, new kinds of ways of thinking about long-term care, like PACE programs, or new kinds of benefits like hospices, and then eventually new kinds of products like biotechnology, which was coming along in those days. You could figure out the FDA things, but how do you pay for that stuff? I was just at the right time and right place.

Berkowitz:

So you knew about the Medicare side as well, right? Because Medicare would become, I assume, important in the payment issues.

Collier:

Well, yes. My first client of any consequence like that was Amgen. They came in the late '80s. They were working on a couple of products. But their first product was going to be

EPO (erythropoietin). In order to finance their company, they had licensed away all the rights to EPO, globally and in the United States, except for its use in dialysis. And so Amgen's first product was going to have one customer, which was Medicare.

And so I was hired, along with a group of consultants and experts. I was kind of the project leader to help them figure out both how to set the price and then I negotiated the price with HCFA over probably an 18-month period prior to its being launched. It was a complex conversation because this was going to be a highly expensive medicine, and something Medicare had never seen before. It was the second biotech product to come to market, and the first one, which was a growth hormone, had not been particularly successful.

We were essentially saying to HCFA, "Look, 300 million has gone into Amgen to get them where they are. It started when Amgen was just a gleam in the eye of scientists and founders. The people who took the risk over the years, as they put their chunk of the 300 million in, depending on when they put it in, are expecting a certain kind of return. We can model what we think the price needs to be against projected volume, costs of goods, etc, in order to give an appropriate return on the risk. If you set the price below that, then there's a good chance that nobody will make any future investments of any consequence in biotech because they won't think it's worth the risk, at least where you guys at Medicare are going to be consequential. It's unusual that you're the only customer for this company, but you're certainly going to be a big customer for every company."

It was a very interesting exercise in financial modeling. We got the I.G. (Inspector General) involved looking at the cost and it was a very interesting project. And HCFA understood the argument, accepted it and set the price prior to launch.

I was actually not much a lawyer by then because I had found myself more interested in the policy and strategic things. I always had a good practice, but I was much more interested in these kinds of interdisciplinary projects where you've got a complex strategic and technical problem to solve, which is not just a legal problem.

Berkowitz:

It also sounds like you also acquired that economic and finance side of it?

Collier:

Yes, it was like everything else. You just learn stuff. I like being a student. I take notes. That's what I've always done.

Berkowitz:

I want to ask you about one last aspect of your career, if I might. You have this very impressive profile of charitable work that you've done. You're involved in a lot of different things, one of which is the hospital there in Boston. I think it's the Newton Wellesley Hospital? That right?

Collier:

Yes.

Berkowitz:

I'm just curious. Knowing what you do about the high cost of these drugs and so on, when you're on the other side of it, and your hospital's trying to manage costs, does that give you a different perspective? How do you integrate these things when you're working on something like that?

Collier:

Well, I think, in the end, the interesting issues around hospital costs are several. But the issue is not so much unit costs. There's much work to be done in bringing down unit costs -- the cost of any particular thing that's given to a patient or any procedures done. I think there's a lot of room to go there, but the big question is bringing down the number of units.

We've known probably for decades that in every single enrolled population, whether it's Blue Cross or Medicare -- but especially Medicare and Medicaid -- relatively few people spend a lot of the money. You can look at what they're spending it on. If you just, for example, organize care such that you could prevent these patients or their caregivers calling 911, you'd reduce hospital inpatient use substantially.

Much of what I think has to be done right now, much of what I find myself thinking about, goes back to hospices, goes back to these basic principles: coherent, interdisciplinary care, delivered by a cohesive team which has responsibility for the whole patient; attention to anxiety and depression and help in coping with the activities of daily living. A lot of these people do not need to be in the hospital. They're just chronically, progressively ill, and they have psycho-social problems; they may need a more efficient place to live; they need help taking care of themselves. In many cases, all that could be done in a much more efficient, effective, and happy manner. As you do that, you'd find fewer 911 calls. We've spent so much money moving through the medical system, essentially to support what, in other places, is a social service.

So I think part of what we've got to do now, because the health system is the place where you at least have money and thoughtful people, is start envisioning techniques for caring and institutions for caring for people, which, in some ways, undertake the social burden and the psycho-social burden equally as they undertake the clinical burden, the healthcare burden.

I think that's where the action is, and if you're Newton Wellesley, a community hospital, you've got to be thinking differently about these patients, because they're where the money is, and therefore the opportunity for making substantial cost savings.

As far as high-cost medicines, if they work, they should be purchased. You can pretty much model what is a fair price. But that model has to include clear clinical benefits, and we've not been too disciplined about that. But it's emotional because a lot of the products are used in oncology. I think we'll see the world sorting itself out. I think the approval processes and the payment processes are going to insist on better demonstrations of benefit, or else you're not going to get paid at all.

I think the big place for cost containment is in re-envisioning the most important institutions, the hospital and the primary care physician. If you think about the hospital, it's really a 100-year-old technology around the technical capabilities and limits we had in the

early 20th century, particularly the need to have the patients physically proximate to doctors and nurses. Same with primary care and the primary care doctor. This is in many ways probably 150-year-old technology. We need to rethink them and take into account the skills and technologies of the 21st century.

Berkowitz:

So the hospital will not just be a theater for the performance of surgery, as someone said, but kind of a different place?

Collier:

Well, that's an interesting question. I sometimes get skeptical about whether the hospital itself can be the center of the kind of system of care that we're talking about. Maybe they're so culturally stuck that what they will be is just contractors to a different kind of institution that gets formed. But at least the hospital has a core there; they've got good, accountable managers, good systems: you can send them a big check; they're going to be responsible about the money. So much of what's being talked about now in terms of variations on these themes -- patients in the medical homes and ACOs, etc -- at some level, if you want people to take a significant amount of financial responsibility, you at least have to be able to trust them with the money, and to have the wherewithal to survive when they miscalculate risk. I think it's a dilemma that the hospitals are the natural place from which to build, but they're also culturally the most inward.

Berkowitz:

Right. Let me just ask you one last question, if I might, that we've asked everybody. And you've already talked about, in a sense. If someone said to you, "What is the future of Medicare and Medicaid?" what would you say?

Collier:

I think what we've seen is that they work really well. They have their limits. To some extent, hospitals were a responsive technology at the time. Blue Cross was a response to the natural demands of the hospitals. Medicare accepted those things; they reacted to those things and adopted them. I think that to the extent that we keep figuring out newer ways to deliver care, Medicare helps with that, helps lead that. I think Medicare runs very well; I think most of us would say we'd be a lot better off if we had a simple all-payer system, and Medicare was that payer. That's a different conversation, but I think anybody who's been involved in Medicare and Medicaid, feels proud of what they've done and very supportive of those institutions.

Berkowitz:

It's interesting that you, as a future-oriented guy, would say that. Some people would say Medicare is like the hospitals; it's part of the old system, something that we need to get around. But you're saying no to that?

Collier:

I think Medicare has turned out to do a pretty good job. It needs a lot of help, and it makes a lot of mistakes, but it doesn't cost as much to run Medicare relative to the dollar benefit and social benefit of its beneficiaries as any Blue Cross plan, much less anybody else. Medicare can drive you crazy, where you're trying to get something covered or get

reimbursement. But it's pretty efficient for the size of it. I'm not an ideologue about government. I can assure you that the big corporations are as inefficient as anybody in so many ways.

Berkowitz:

And for Medicaid?

Collier:

You have to feel bad about Medicaid because in the states the politics are so much more immediate and so much more troublesome. The good Medicaid directors are fantastic people, and they really are really trying. But, whether it's crooked legislatures or just stupid legislatures, it's a much tougher environment. But Medicaid is an essential part of our lives, and it has to be. I think people do the best they can, but it's tough; it is tough to do that stuff at the state level. God bless them; the people working on Medicaid. Good people, they keep working at it.

Berkowitz:

Thank you so much for doing this; really appreciate your taking the time.

Collier:

I appreciate it. These are important topics, so thank you.

Interview with Nancy-Ann Min DeParle

Washington, DC on April 2, 2015

Interviewed by Edward Berkowitz

Transcript edited for clarity.

Berkowitz:

Today is April 2nd and we are here in Washington, D.C. and I'm talking to Nancy-Ann DeParle, who has had an amazingly varied career in the health care field and other fields as well. I want to ask you to reflect on your career, if you would. One of the most important things you've done, obviously, is to work on the Affordable Care Act of 2010. My question is a comparative one. The ACA builds on previous reform efforts such as the Balanced Budget Act of 1997, and I was curious how your experience at HCFA with Medicare and Medicaid came into play in your work on the Affordable Care Act?

DeParle:

Well, I guess it came into play in a couple of ways, not so much from the policy perspective though. The piece of my past that came into play from a policy perspective was having worked at the Office of Management and Budget when I was the Associate Director for Policy Personnel before I went over to run HCFA. And I worked for at OMB for the first two years of the Clinton administration on President Clinton's health reform effort. Two years? One year? So it seemed like a longer time than it probably was.

It's a rather painful memory. As you will recall, we couldn't even get a Senate committee to vote on President Clinton's health reform bill. But I spent at least '93 -- all of '93 and maybe up until some part of '94 -- working on that effort from my capacity at the Office of Management and Budget. And I learned a lot from that effort about working with the Hill. There were similarities and differences between the Clinton and Obama approaches to getting health reform legislation through Congress. When President Clinton took office, Democrats had the majority in the House and Senate; therefore all the committee chairs of jurisdiction were in the same party, so that would seem to suggest that we could get reform done. But President Clinton did not try to get healthcare reform done first, as President Obama did. Clinton let other things take priority, such as the budget which turned out to be quite contentious and I think cost him valuable time.

President Clinton also took a different approach in that he sent a bill to Congress. His administration spent, famously, months in these so-called "toll gate" sessions having meetings to develop the policy internally at the White House, using some external advisors, and then drafted a bill and waited until, I believe, September of 1993 to send the bill to Congress. And so much time had been spent by then, and so many other battles had been fought -- it allowed the "honeymoon" period to end with our Democratic Congress, and we just got to a point where there just wasn't the support to do it.

So I had all that as context when President Obama called and asked me to come help him. The experience of HCFA, the relevance of it, was probably the experience of coming into that role as Administrator at a time when the Congress was controlled by the other party

and trying to do some rather large things to change the Medicare and Medicaid programs and the Children's Health Insurance Program. It was very challenging but also a really helpful background for me to have coming into the Obama White House. Now, we had a majority of the House and Senate in 2009, so you could say, "Well, why did you need to worry about that?" But what I learned during my time as HCFA Administrator was how important it was to have both parties' ideas and thoughts and perspectives represented in any big change in healthcare. And so it just gave me the background to work more effectively with both Republicans and Democrats. And a number of the members of Congress that I worked with when I was running HCFA were still there -- some of them had moved to the Senate. So many of the people that I had worked with closely were still there either in the House or the Senate -- Republicans and Democrats -- and that was a helpful perspective, too.

Berkowitz:

When Medicare and Medicaid were being created in 1965, the elephant in the room might have been Harry Truman's failed efforts to get national health insurance passed -- it gave health reform a kind of negative connotation. Was the Clinton effort the elephant in the room for the Obama effort? Did that come up in meetings and so on?

DeParle:

Occasionally, but it didn't come up overtly. I don't recall it coming up at the White House overtly, but I think for those of us who had been around for that effort -- and there were a few of us, myself and Phil Schiliro, who was the legislative director for the President, and Rahm Emanuel, the Chief of Staff -- the spectre of the failed Clinton effort was kind of always hovering in the background. But most of the people weren't involved and I don't recall us speaking about it directly. Many of the members and staff on the Hill were involved in the Clinton effort, however, and I do think it came up in a positive way there. And I'll give you an example why I think that's the case.

By the way, I take issue a little bit with the way you posed the question because that may have been the negative elephant in the room but from what I read, and you're the historian here so you tell me what you've read -- but what I've read, one positive aspect of history was the fact that President Kennedy had tried and hadn't been able to get Medicare passed.

Berkowitz:

That's definitely the case.

DeParle:

President Johnson wanted to get it done --

Berkowitz:

Right.

DeParle:

-- and he was able to use and deploy the emotion, I think, around a fallen President and his legacy.

Berkowitz:

It's no accident that it passed in 1965.

DeParle:

Right. And now that I've brought up LBJ, I will get to your question. But I do want to tell you something that is kind of interesting. So the first thing I did when I got to the White House and found an office and a computer was to type out a quotation that is attributed to President Johnson, which is -- I may not get this right; you'd think after looking at it every day for four years I would get this right! --

"There is but one way for a President to work with the Congress, and this is continuously, incessantly, and without interruption." The story goes, this was what he used to tell his team. According to the histories that I've read, right after President Johnson was elected when he felt he had a mandate, which he did, he immediately started calling his team in and saying, "Okay, I want to pass Medicare right away. It's got to be the first thing we do; we're losing steam every day." According to what I read, some of his aides were astonished because here he'd been elected by this big mandate but he perceived it as a mandate that would decline quickly, like the sands of the hourglass going down. And he knew that Presidential power dissipates very quickly, very quickly --

Berkowitz:

That's correct. He called the people together and he said "Every day that passes I'm going to lose some of my power; I'm going to alienate someone, so we have to push for this".

DeParle:

Right, right.

Berkowitz:

-- and that's why a lot of those things passed in 1965.

DeParle:

Exactly, exactly. So that was my mantra. And President Johnson's approach to Congress became my mantra: I knew that what I needed to be doing every day was not sitting in that Executive Office Building or the West Wing writing memos, but up on the Hill talking to Senators and members of Congress. And that's what I did. I was up there virtually every day going from office to office meeting with members, spending just hours and hours, because to get them where we needed them to be, that's what it took.

So it was that reform -- LBJ's passage of Medicare -- that was definitely hovering over me. But the Clinton bill was also hovering for the few of us who had been around then. President Obama wasn't involved and most of his team was not. But for those of us who'd been involved, it hovered over us. And I think it guided two very key decisions that I've already alluded to. One decision that his legislative director, Phil Schiliro, presented to him was: "If you've decided, Mr. President, that this is what you want to do, if you want to get climate change done and you want to get healthcare done, then you have to go quickly," and he did. President Obama very quickly passed in the House the climate change bill. The House passed it at the very beginning of the summer, and then turned immediately to healthcare. We were already working it hard; the Speaker could have been ready to mark

up a bill early. She didn't because she was waiting to time it with the Senate and thus ended up waiting until July, but she was poised. And the second decision was not sending up a bill because we had seen that by drafting the whole thing out and making a bunch of these decisions, even if you consulted with Congress, if you put it down on paper and then sent it up there that just didn't go well.

And the reasons are many, but chiefly I'll use the House as an example, though the Senate's no different. In the House you had three committee chairs that had all spent their careers, 40 years at that point for three of them, in Congress, and here you had the biggest piece of legislation that they were probably ever going to work on, and they get a draft from the White House? They didn't want that. They wanted to come up with their own draft of the bill.

But the way in which the Clinton failure, I think, changed the dynamic in the House was that Speaker Pelosi was not going to let what happened in '93 and '94 happen to her. She was determined to get a bill, and she was determined to get her committee chairs working together. The three committees that had jurisdiction, Education and Labor, Energy and Commerce, and Ways and Means, they had somewhat different pieces of health reform legislation but there was a lot of overlap. And in the Clinton health reform effort, each committee tried to mark-up separate bills; they each tried to draft separate bills. So they were all singing out of different hymnals, so to speak. And so one of the first moves the Speaker made, at our request, was to sit down with the three chairs and say, "We're going to work on the same bill." And they wrote a letter to her committing to do that. People don't ever talk about this, but it was a huge step forward: it is just an unnatural act for a chairman of the committee to say, "I'm not going to draft it, I'm going to let Ed draft it," or "we're going to do this together."

The second way in which the Clinton health reform failure had a positive impact on Democrats in Congress was in galvanizing the commitment and determination of the staff. It was March of 2009 that I joined the White House, and I started going up to meet staff on the three committees. And at the time I started, the Democratic staff of these three committees was not exactly sitting around singing "Kumbaya." They just hadn't worked together on legislation in recent years, and they'd been in the minority. There was a lot of distrust. It took a lot to get them all to start working together. But I think the failure of the Clinton healthcare reform made people realize time is our enemy here and if we want to get this done we have to put aside some of our more selfish [laughs] motives and our need to be the only person at the table. We have to get beyond egos and really work together, and to their credit, they did that.

Berkowitz:

It occurs to me too that the history is that the John Dingell, Henry Waxman committee was fighting about Medicaid with the Ways and Means Committee for a very long time.

DeParle:

Right.

Berkowitz:

That's why the structure is different in the House than it is in the Senate. And that kind of thing carried over many years --

DeParle:

So Henry Waxman, who had been working on healthcare for years, has finally gotten to be the chairman of his Committee. You had Mr. Rangel at Ways and Means, but underneath him Pete Stark who'd been chair of the House Subcommittee of Ways and Means for many, many years, and you had George Miller at Education and Labor. Each of these guys had been in for almost 40 years and three of them were Californians. Rangel also had been through this effort before, and I think they just all saw that it didn't work before and that they were responsible for some of the problem for not figuring out how to work together. They had wasted time arguing, and they weren't going to do that this time. And they didn't...

Berkowitz:

It was legacy time for some of them, too.

DeParle:

I think so.

Berkowitz:

Some were not going to be around much longer --

DeParle:

That was unspoken but, yes. And I also think a huge factor in this was Speaker Pelosi. I can't emphasize enough her determination and her strength of leadership. She was the leader, and she twisted arms if she needed to. You know, she was the LBJ of this in some ways. She was the "master of the House" as LBJ was the master of the Senate as (historian Robert) Caro portrays him.

Berkowitz:

Right, right.

DeParle:

She was that in the House. She had that role.

Berkowitz:

That's interesting to hear that take on her leadership. I was thinking also when you said that that the politics of 1965 were affected by the assassination of President Kennedy in 1963. Of course, that sort of comes up again, doesn't it, in the Obama health plan, with Ted Kennedy's death in 2009?

DeParle:

Yes, it does.

Berkowitz:

So that must have been something that you observed as it happened?

DeParle:

Yes, and in the difficult days after that, in the Senate and the House, we came to the realization that there will be no Republican support for this bill. That was very sobering because the President really wanted it to be a bipartisan bill. And my colleague Rahm Emanuel famously says, "Well, it has a lot of Republican ideas even if they didn't vote for it," and that's really true. I can spend hours with you going through the provisions that various Republican members contributed and they were good, sound proposals and that's why we said, "Yes, you're right, that should be part of this."

Berkowitz:

Not to mention Romney's setting the table for this.

DeParle:

Exactly, not to mention Romney setting the table for this particular construct with the Massachusetts reform. Not to mention the years, starting right after the Clinton reform failed, the strange bedfellows that started up then with Chip Kahn of the Federation of American Hospitals and Ron Pollack who ran Families USA, the progressive group, working together on a policy be that would get everyone covered, reform the insurance markets, change the delivery system. So the groundwork had been laid by a lot of bipartisan strange bedfellows, for lack of a better term, over 12 to 15 years in the aftermath of the Clinton failure. But Senator Kennedy -- both his legacy and his having been a creature of the Senate in the best possible way, and being bipartisan -- I think all of us felt that if he had lived we might have stood a better chance of getting one or two, three or four Republicans to support the law. He was just that effective and just had so many decades of friendship and having worked across the aisle.

So that was a huge loss. But I felt in those caucus rooms going up to the votes in the Senate that I could see in some of the senators asking themselves, "What would Ted do?"

Berkowitz:

[affirmative]

DeParle:

Or thinking, "Ted would want us to get this done." And you heard it explicitly on the day of Senate passage, Christmas Eve. I think this was the second longest floor debate in Senate history, second only to the Civil Rights Act. Majority Leader Reid did an unusual roll call vote where Senators sat at their desks, and Senator Byrd stood up and said, "This vote is for my friend Ted Kennedy." Senator Byrd hadn't even been here for most of the summer and fall leading up to this because he was so ill. But they wheeled him in and he went over to his desk and he stood up and cast his vote. So that definitely hovered over the whole thing.

Berkowitz:

That's interesting. So it seems to me, I could be wrong, that the Balanced Budget Act of 1997 set up a lot of different things that persisted like SCHIP (State Children's Health Insurance Program) the Medicare Plus Choice. These new programs play a role in the ACA as well. Is that reasonable?

DeParle:

SCHIP was an interesting model in that it was one where we worked with the states to implement it, and it took some time for all the states to accept it. Some states immediately moved to begin an SCHIP program. Others, like Texas, took several years.

That's something that I think has been relevant and looked to in the last couple of years as HHS (Health and Human Services) and CMS (Centers for Medicare and Medicaid Services) have been working to try to implement the Affordable Care Act. Originally this wasn't supposed to be implemented by CMS. But because the Congress wouldn't give Secretary Sebelius the resources to launch a new operating division within her department to do health reform, it fell to CMS to do the market places and the other pieces of it. CMS would have done Medicaid and Medicare, but it wouldn't have done the exchanges, and the tax credits, and all that.

Berkowitz:

How did the Affordable Care Act come into your life? Was it a phone call from the President?

DeParle:

It was a phone call from Rahm Emanuel, the Chief of Staff.

Berkowitz:

And he said, "The President is interested in having you work on this project?"

DeParle:

Yes. "Could you come talk to me?" It came in on a President's Day weekend of 2009. I was away with my family, and we were driving back home around 9:00 p.m. that Monday night. And a call comes in on my cell phone from the White House, and I thought it was a joke at first. It was Rahm, who I'd worked with in the Clinton Administration, saying, "Could you come and talk to me?" It was right after Senator Daschle announced that he was withdrawing and would no longer be the person who would be driving the health care act at the White House. I told Rahm I couldn't, that I had just started a new firm, and I couldn't step out of that, and it wasn't a good time for my family. And he said, "Why don't you at least come in and talk to me, help me, and give me some ideas?" And I said I didn't even have time to do that because I was so stretched-- my business travel was so intense, and I was headed to California for a week. I hung up and actually my husband said, "You weren't very nice to him," --

Berkowitz:

[laughs]

DeParle:

-- I said, "I'm not going to do that, I'm not going to go back down there! I know what that's like. I've done that, that's in my past; I'm not going back to the White House." In fact, I loved my time at CMS, even as challenging as it could be sometimes. And I would contrast that with my time at the White House in the Clinton administration, which I did not enjoy nearly as much. So if someone had said, "Come back and run CMS again," I probably would have said no, but I would have been more interested at first blush than I

was in going back to the White House, just because of the lifestyle and the demands. In the White House, you are not in control of your own life; at CMS, you more or less are. You're running an agency and you have a team of 5,000 people to help you.

Berkowitz:

Right, you're the boss.

DeParle:

It may or may not go well, you may make mistakes, but at least you're running it, and that is more to my liking than the White House experience was, at least in the Clinton administration. So when Rahm called, I really wasn't interested. He persisted though; he kept calling me and then finally, a couple of weeks later, he called on a Friday and he said, "I'm in here tomorrow, can't you come in tomorrow, it's a Saturday. Surely you're not traveling on business on Saturday?" which, was true, I wasn't. So I agreed to go in and talk to him then.

Berkowitz:

And then that closed the deal.

DeParle:

No, it wasn't the closer. My husband's urging me to do it was the closer. Rahm and I chatted about it, and I had come up with some other names for him. I gave him some other ideas. And with each one of them, he listened and then he'd say, "No, no, no, that's such a steep drop off from you to that person, they couldn't do it. Here's why: we think you have good experience working with Republicans in Congress, that's going to be important to this."

And I said, "I've never passed a bill before, that isn't what I did at CMS." And he'd say, "Yeah, but I'll help you with that," and he had a response for everything. And then he went down the hall and he said, "Excuse me for a minute," and I knew what he was doing because I'd seen from when I came in that -- you can tell by the way the Secret Service is positioned whether the President is in the office or not on a Saturday. So I knew that President Obama was a few steps down the hall in the Oval Office... So Rahm got up to go out and I said, "No, you're not going to do that to me," because I knew he was going to try to get the President to come down and talk to me. And I said, "I just don't think I can do this, Rahm. I appreciate your wanting me to do it, but this is not the right time in my life to do it." And he said, "Well, I'm not going to give up. I'm going to have some other people call you." So he had Melody Barnes call me, he had Jim Messina call me. He might have even have had Tom Daschle call me; he had a series of people call me. And on a Sunday night, they talked me into it, and the next day they were planning to announce the appointment of Kathleen Sebelius as Secretary.

So they got me to agree Sunday night, and he said, "Can you be here tomorrow at 10:00 a.m. or 11:00 a.m.?" I said, "Well, I guess, but why?" And he said, "Well, the President is announcing that he's going to nominate Kathleen Sebelius and we'd like to announce you at the same time."

And it's probably good that he did that because if he had given me more time. I thought my husband would say, "You're absolutely right, you shouldn't do it," but that isn't what he said. Instead, he said "If the President thinks he needs your help, you should do it. I don't want you to look back and regret not doing it. "

And I was worried about the impact on our family, and he said, "Well, we can manage this for a year."

And the other deciding factor was that Rahm argued to me that this is a 1-year commitment, because health reform will either happen or won't in a year. And as I thought about the way Congress works, I realized he was right. I was very surprised that the President was choosing to pursue health reform because it's so hard. By then it was clear that the economy was in a free fall. And also during the campaign he'd left himself room not to do it. And I had paid a lot of attention to this; in one of the debates he said something to the effect of "I intend to sign healthcare reform legislation by the end of my first term." And to those who know the rhythms of Washington, that left open the possibility that he wouldn't do it because, as I said, anyone who watched the Clinton plan would agree that a President has a honeymoon period at the beginning of his term and it's very unlikely to get something that big done at the end of your first term. A lot of miracles have to happen for something big like this to occur at any time, but for it to occur at end of your first term? Not many presidents are that lucky.

So I thought he was leaving himself room not to do it. But once he had decided to do it, it struck me that Rahm was right that it would be a 1-year effort, because there comes a time in every electoral period when the members of Congress' attention turns from the President's agenda to their own re-election. And so it seemed clear to me that sometime early in 2010 health reform would either pass or lose steam. It was either going to happen or not. That's what made me in the end decide to do it. I also thought that even though I don't think I'm the right one-- even though this is a terrible decision for me financially and probably from a family perspective--it's not like the President is asking me to go to Iraq; many people have had to make far greater sacrifices.

Berkowitz:

That's interesting. I've looked at the television tape of the news conference at the time of your appointment, and you're there, and I had a sense that the people in the audience were wondering what was going on.

DeParle:

It was a big surprise, yes.

Berkowitz:

Lyndon Johnson also loved to pull surprises on the press.

DeParle:

And they surprised me because, literally, we had 20 minutes before we went out there. I came in and met with the President that morning, and he looked at me and said, "Well, here's what will happen, and you won't have a speaking role. Governor Sebelius has prepared remarks, but you won't have a speaking role." So I said, "Fine." And then at the

actual event he turned to me and said, "Do you want to say anything?" -- which wasn't what I'd expected.

Berkowitz:

As I recall, Congressman Waxman was there, right?

DeParle:

Yes.

Berkowitz:

And several other health policy people. And he mentioned them, but they didn't speak, as I recall.

DeParle:

Right. They all just got called that morning and there were others who couldn't come. It was the first four or five weeks of the administration. They'd just been in since January 20th, not even two months.

Berkowitz:

But as you were saying before that's the Johnson rule: you have to do it quickly and, as it turns out, Johnson was definitely right. Did you know Secretary Sebelius before that?

DeParle:

Yes, I did.

Berkowitz:

How did that come about?

DeParle:

Well, this does go back to the Balanced Budget Act. When I became the head of HFCA, as you said, I was implementing the Balanced Budget Act. Well, actually, before the Balanced Budget Act, among the things we were charged with implementing was HIPAA, the Health Insurance Portability and Accountability Act.

Berkowitz:

I, like every other patient in America, am more than familiar with HIPAA.

DeParle:

Yes, yes. So that even passed before the BBA, maybe in the spring of that year? But the agency was just starting to make plans to implement it, and I was talking to Secretary Shalala about it and I said, "You know, this is new for this agency." States are in charge of regulating insurance markets under the McCarran-Ferguson Act (1945), not the Federal government. There was really very little Federal law about health insurance. That had been pretty much ceded to the states. And it wasn't huge, but there were some changes in the law that were given to CMS to oversee, and some to the Labor Department... And I said, "We need some insurance experts. We have plenty of Medicare experts but not too many commercial insurance experts." And Secretary Shalala said, "Well, you know, I've been chairing this commission." It was a commission that had a long name but its short name

was the Quality Commission. She co-chaired it with Alexis Herman, who was Secretary of Labor. And she said, "There's a woman serving on that as a commissioner who is the representative of the National Association of Insurance Commissioners (NAIC). Her name is Kathleen Sebelius." Kathleen was the insurance commissioner in Kansas at the time.

And she said, "Why don't you call her up, she seems really smart. Maybe she can help you?" So I called her, and she couldn't have been nicer or more helpful. It was before I was even confirmed as HCFA Administrator; I took her to the White House for lunch. And I asked for her help, and she said, "Absolutely," and she invited me to come to the NAIC meeting. They met several times a year and I came to one of the meetings. I asked them for their help and the context here is important because the NAIC was not exactly happy about some of the changes that were being made through HIPAA. They weren't happy that it was being done through the Federal government. All the notices that we get as patients now that you have to sign -- that wasn't really the big deal at the time, oddly enough, although that's how most people think of HIPAA. What upset them were insurance reforms, very minor, some minor portability changes, and some COBRA (Comprehensive Omnibus Budget Reconciliation Act) changes and some things like that that were being given to HCFA to oversee for the first time ever and not retained by the states. So the state insurance commissioners were a little bit edgy about it.

And Kathleen really helped me because she was the chair of the NAIC. She took me there as her friend and colleague and said, "She needs help and we should help her," and they did. And she helped me find someone who'd been a state insurance commissioner to come work at HCFA.

So we became friends through that. And then I saw her a few times after the Clinton administration when she was running for governor of Kansas.

Berkowitz:

I see.

DeParle:

And I think that was an important context, and the decision by Senator Daschle (President Obama's first nominee as Secretary of Health and Human Services) to insist on also having an office at the White House was also a legacy. I have never talked to Senator Daschle about it, but it was reported at the time that he insisted on that because he didn't want it to be the way it was in the Clinton administration, where you had Ira Magaziner doing everything at the White House and leaving HHS Secretary Donna Shalala in the dark.

Berkowitz:

Donna Shalala is not an unforceful personality herself.

DeParle:

Right, and so Senator Daschle didn't want to be in that position. I think the White House rightly wanted his expertise because obviously he had passed things in the Senate before. So he knew how to do it.

Berkowitz:

The Henry Kissinger precedent: he was both national security advisor and Secretary of State. So, then, I guess you kind of understood your respective jobs. You were working on this bill, trying to create it and she was running the Department, but with the understanding that that if this bill passes, it's going to be implemented by the Department.

DeParle:

Right. And Secretary Sebelius and I had a great relationship and she was a very forceful advocate. We had a number of policy meetings at the White House to discuss the ways that the House and Senate bills were developed, and how the bills were shaping up. And she was always in those meetings. I made sure she was there and she also played a huge role as an effective spokesperson on the Hill. And when there were mark-ups or hearings about it, she was the person who went up there because White House staff members don't testify in front of Congress. So she was very important, and we worked very well together.

Berkowitz:

When you wanted to call HHS, whom would you contact?

DeParle:

Jeanne Lambrew. She was supposed to be Senator Daschle's deputy who would work at the White House and manage the Office of Health Reform for him while he was over at HHS. And when he chose not to go forward, Jeanne decided that she would prefer to be at HHS. So she went to HHS and she ran an office over there, a very small office, to help with health reform. And so she was the "go-to" person there.

Berkowitz:

I see. Okay, now we're getting toward the end of our hour but one or two more questions, if I might. Here's another historical story for what it's worth. In 1935 when they're passing the Social Security Act it turned out to be much harder than anybody thought it would be and at time when they had enormous margins in both the House and the Senate. So they called upon these people in the social welfare community. One of them was Jane Addams, the famous social worker, who was asked to appeal to Congress. I was curious if there was anything analogous to that in the Affordable Care Act.

DeParle:

Well, yes. There was an Office of Public Engagement at the White House that worked with all the different stakeholder groups who wanted to help pass reform. The President had said that he would have as much of this on C-SPAN as possible. So when I first got there we were doing one or two meetings with outside groups a week that were on C-SPAN. We had a bunch of hospital executives there, consumer representatives, et cetera. And C-SPAN lost interest, even --

Berkowitz:

[laughs]

DeParle:

-- they thought it was too boring to telecast these two hour meetings.

Berkowitz:

Boy, that's something if they thought it was too boring --

DeParle:

Well, you know going around the table there's only so many people -- so we had probably eight or 10 of those meetings that were televised, but we kept doing them with different groups. And then, this is something Senator Kennedy, among others, gets credit for, but remember that two years before healthcare reform started, he began having meetings in his office with a lot of groups. And they weren't all the usual suspects. He made the Chamber of Commerce come, he made groups that said they weren't even sure they could support it come and meet together and talk about, "What could you support?" That kind of thing.

And so there were already groups that had been formed and were doing things on their own. As a historian, I think you'll find this interesting, Ed. So you've read, I'm sure, the various histories of the Medicare law. And the hospital association played a positive role in helping to get Medicare passed. The AMA (American Medical Association), by way of contrast, fought against it, tried to stop it.

The AMA played a very different role this time, different even than from what I remember from the Clinton administration. This time the American Medical Association and its leadership were really steadfast in support of reform, even though, in the end, as with all groups, there were a few things they wanted to see in the bill and one of them that was key to them still hasn't gotten done. It's the SGR (Sustainable Growth Rate) -- the so-called the SGR patch to the physician payment formula.

That goes back to the Balanced Budget Act. I think that's where it was first put into law. It's the basis of their reimbursement under Medicare, and it also has ripple effects throughout all of healthcare because most physician reimbursement is based on that in some way. Right now under the formula they would be getting a 31 percent or something cut in their fees, which no one thinks is appropriate. But that's in the law, and they want to get it changed and the President proposed in his budget in February of 2009 to change it, to repeal that former provision and change it, but we weren't able to include that in the law, in part because of the cost.

And so in the end, the AMA had to make a decision in March of 2010 as to whether they would continue to support the health reform legislation even though it didn't have the thing that they and their membership cared the most about. And to their credit, they did. What I saw was a very different focus on what's best for our patients that I did not see in 1994. And I think it's in part because things had gotten so bad. I think that doctors saw the numbers of people without insurance and numbers of people whose insurance didn't cover the services and treatments they needed. And they just realized that they had to support change. I give them a lot of credit for helping us get this done.

And the AARP, by the way, which, you know, arguably was if not created by Medicare and Social Security at least that's a big part of their *raison d'être*. They supported reform. They had something in it; there are some changes to the prescription drug benefit. But arguably not as much as they've gotten in other bills.

Berkowitz:

Yes.

DeParle:

Now, I think they supported it for two reasons. One, there's a part of their population that's age 55, not 65, and those people have been left without insurance in disproportionately high numbers because they tend to want to change jobs or they lose their job and then they can't get other insurance because they tend to also be in the age group that starts having pre-existing conditions. And so there was that reason. And the other one was their members said, "We see our children and grandchildren unable to get insurance or having insurance that doesn't cover their health needs. And we want them to have more health security."

Berkowitz:

That's interesting.

DeParle:

So they played a very important role.

Berkowitz:

In 1960s you could say, "Well, the government coming into this market may or may not happen," but you couldn't possibly say that by the time President Obama was elected.

DeParle:

Right. Because we had Medicare, we had Medicaid, we had SCHIP. But if the AMA had chosen to oppose it, if the AARP had chosen to oppose it, that would have been very problematic.

And there's a woman named Sister Carol Keehan, who was the head of the Catholic Health Association, who played a really important role when all the struggles came up about whether abortion would be covered, which it isn't, but there were also concerns about contraception, which is. She played an important role in saying, you know, "we want people to get coverage and that's the important goal here." She was a steadfast supporter of the Affordable Care Act though some contentious times.

She was probably the Jane Addams.

Berkowitz:

Last question, if I might. We talked about this before a little bit, but your career is so interesting in that you have experience both in the private and the public sectors; you've been in and out of government, and right now you're working in the private sector, right?

DeParle:

I went back to what I was doing. I co-founded a private equity firm called Consonance Capital with some of my former partners, and we are partnering with innovative health care companies.

Berkowitz:

All right, well, does one thing inform the other?

DeParle:

Oh, definitely. And in fact, I was told by Rahm that one reason why they wanted me to come to lead this effort was because I had the experience in the private sector as well as government experience. The President very much wanted the law to be grounded in what was happening in the private sector; the so-called “government takeover” that some of his opponents have accused him of is the last thing he wanted. He wanted it to be based on what’s happening in the private sector now.

Berkowitz:

So you brought that to the table?

DeParle:

Right, hopefully I did.

Berkowitz:

Thank you very much.

DeParle:

Thank you.

Interview with Henry Desmarais, M.D.

By telephone on May 27, 2015

Interviewed by Edward Berkowitz

Transcript edited for clarity.

Berkowitz:

Today is May 27th, 2015, and I'm talking by telephone to Dr. Henry Desmarais, who is in Washington, DC. Is that correct?

Desmarais:

That's correct.

Berkowitz:

I wanted to talk to you a bit about your life and the work that you did for HCFA in the 1980s and then beyond in the healthcare field. So, maybe we could just start. Where did you grow up?

Desmarais:

In Nashua, New Hampshire.

Berkowitz:

And I know you went to Yale to go to medical school. I was wondering where you went as an undergraduate?

Desmarais:

Saint Michael's College in Vermont.

Berkowitz:

So, you lived in Vermont, and then went to college in Vermont. When did you decide that you wanted to become a doctor?

Desmarais:

Probably during my college years. I'd actually majored in biology and thought about a number of different options and ended up settling on the medical track and then applied to medical school.

Berkowitz:

What was your specialty? What was your field?

Desmarais:

I have a fairly unique track in that after medical school, I actually decided that I was more interested in the public policy field and ended up going to work on Capitol Hill in the House and then in the Senate. I was working for members of the New Hampshire delegation. In the Senate, it was a Republican who -- when the Senate went Republican in the 1980s --

chaired a subcommittee on what is now the HELP (Health, Education, Labor and Pensions) Committee but was the Labor and Human Resources Committee in those days. I was the Staff Director for that subcommittee for some time and also on his staff for two and a half years.

Berkowitz:

Not too many people with a medical degree take entry-level jobs in a congressman's office. So, it must have been pretty unusual in that respect. You worked in the House for someone, you say, from the New Hampshire Delegation? Who was that?

Desmarais:

Jim Cleveland. He was a Republican, 2nd District of New Hampshire. He is deceased. He had been in Congress for 20 years; I guess between his military service and his congressional service it was over 20 years. So he retired and when he did, I was offered a job in the Senator's office. This was just before the 1980 elections. With those elections, the Senate went Republican. And so, I was now working for a member of the majority who became chair of three subcommittees, one of which was on the Labor and Human Resources Committee.

Berkowitz:

And that was Senator?

Desmarais:

Gordon Humphrey.

Berkowitz:

All right. So, you eventually get on the staff of this subcommittee, and just to be clear, that's the subcommittee of what?

Desmarais:

It's the subcommittee of what was then the Labor and Human Resources Committee but is today the Health, Education, Labor and Pensions Committee.

Berkowitz:

That was the Harrison Williams Committee and, later, the Edward Kennedy Committee. Right?

Desmarais:

[laughs] Well, at the time I was there, it was the Orrin Hatch (R-Utah) Committee. The Republicans were in charge. But Ted Kennedy (D-Massachusetts) was the ranking member at that time, and the subcommittee was the Subcommittee on Alcoholism and Drug Abuse.

Berkowitz:

It's not real clear to me what this subcommittee does. What does it investigate or what does it do?

Desmarais:

You mean the overall committee?

Berkowitz:

The Senate Subcommittee on Alcoholism...

Desmarais:

Each Congress the organization of a congressional committee can change, and in that particular year, health issues were handled at the full committee. There was no subcommittee on health, but there were a number of subcommittees. One of them was the Subcommittee on Alcoholism and Drug Abuse, which addressed issues with respect to alcoholism and drug abuse, and also oversaw the National Institute on Alcohol and Alcoholism issues. So, in terms of authorizations of various federal programs, that would be within the purview of that committee. And also, certainly, looking at how that money was being spent and whether it was being spent effectively and so on. That subcommittee doesn't exist at this point, but that's not unusual. As I said, each Congress, some of the subcommittees may go away.

Berkowitz:

I assume that Orrin Hatch was not a member of that subcommittee.

Desmarais:

Actually, I believe Orrin was. It's a little vague now. We're going back a couple decades, so I forget exactly the composition of the subcommittee.

Berkowitz:

So, even though Orrin Hatch officially doesn't drink because he's a Mormon, he was on this committee about alcoholism?

Desmarais:

As I said, I don't recall if he specifically was. He was the overall Chair, but Gordon Humphrey was the Chair of the subcommittee.

Berkowitz:

And so, you did things like put together hearings?

Desmarais:

Correct. We had hearings, and in that time, authorizations were done at that point as well as part of larger pieces of legislation.

Berkowitz:

It was kind of a unique way of taking advantage of your background as a doctor, too?

Desmarais:

Right. And of course, just to be clear to the way these subcommittees were staffed, I was really on the Senator's personal staff but functioning as the Staff Director of the subcommittee. There were full committee staff that would have been on the committee's payroll, but there are a lot of different lines drawn between whose payroll essentially you are on. But obviously, I was not only handling the subcommittee work. I was also

handling all of the work that was involved with the full committee. So, every time the committee had a hearing on any of the topics in its jurisdiction or was considering legislation, I was helping to staff the Senator on those issues.

Berkowitz:

I'm trying to think about the NIH (National Institutes of Health) structure at the time there. There was a national institute for drug abuse or some such thing?

Desmarais:

Yes. That was really not part of NIH, though. It's part of ADAMHA (Alcohol, Drug Abuse, and Mental Health Administration). So, it's part of a whole separate structure that looks at mental health issues and alcohol and substance abuse issues.

Berkowitz:

Okay. So, we're now talking about the Reagan years. Were you a Republican?

Desmarais:

Yes. Although, to be honest, when I was first looking for a job, I hadn't solidified those credentials and hadn't voted very many times. But having done that, since my days on the Hill, I've considered myself a Republican.

Berkowitz:

To go back just a little bit, did you get a lot of resistance from Yale Medical School to your idea that maybe you wouldn't be a clinician and you would be a public policy guy?

Desmarais:

Well, quite honestly, that was my decision and it was made after I had graduated. So, it wasn't like I was sitting at Yale at the time of graduation, thinking that this was the track I was going to follow, and, in fact, had been accepted to do a residency in internal medicine at Georgetown.

Berkowitz:

So, instead, you just never took that residency?

Desmarais:

Correct. Right.

Berkowitz:

I see. Of course, now there are lots of fellowships and various ways of facilitating this link between the medical world and the policy world, but not so many at that time, I would imagine.

Desmarais:

That's correct. It was much rarer then than it is today. In fact, it was quite rare to have any kind of medical background on the Hill. We used to have a small group of us, who were physicians by training and nurses get together, and it was a very, very small group at that time.

Berkowitz:

It seems to be that Senator Kennedy often had a doctor on his staff.

Desmarais:

Right. He also had a nurse, but it wasn't common. There were a handful of people on both sides of the Hill that had a medical background that were actually working on health policy issues.

Berkowitz:

So, let's get to your work that you did at the Health Care Financing Administration. Maybe you could take me through the process of your appointment there. Was your initial appointment at HCFA as Executive Associate Administrator?

Desmarais:

No. That was the end of the four plus years.

I was hired to be Director of the congressional staff, in the Office of Legislation and Policy. And the congressional staff was the folks who basically received inquiries from individual members of Congress when their constituent had an issue with Medicare or Medicaid and had questions or wanted more information or whatever. We were the entry point for the typical member of Congress -- not the committees, but for the typical member of Congress for casework or constituent inquiry or whatever.

From there, I was asked to be Director of what was then called the Bureau of Eligibility, Reimbursement, and Coverage. In those days, that was the central part of the agency that handled all the Medicare and all the Medicaid policy making. All the regulatory development, manual instructions, et cetera were developed including all the national coverage decisions. The agency has transformed itself enormously, as you might imagine, since the late '80s in terms of how it does business. But in those days, everything was pretty centralized. We had a policy bureau and an operations bureau, and the operations bureau handled all the Medicare contractors and so there was a certain amount of coordination between the two big bureaus within the agency.

Berkowitz:

Was there also a separate Medicaid bureau?

Desmarais:

No. At that time, there was not. That's why I say it was just a Bureau of Eligibility, Reimbursement, and Coverage, which applied to both Medicare and Medicaid, but today, we have a whole separate center for Medicaid and CHIP.

Berkowitz:

I would imagine Medicare must have been a big casework thing for congressman and a lot of people are involved. Was that the case?

Desmarais:

Yes. There are always questions. Why is this happening? Why is this nursing home having a problem? Why is this nursing home being threatened with sanctions because of failure to meet the conditions of participation?

The typical member of Congress doesn't sit on a health committee. They don't know where to go, and they come and say, "I don't understand what's happening. Why are my hospitals all upset?" At HCFA, there's a staff that would try to provide an answer back for them. It's not a legislative kind of activity. It is casework.

Most of the agency was based in Baltimore, not where it is today, but near the Social Security Administration in Woodlawn. And so, the staff in Washington would make a bunch of phone calls and try to determine as best they could what might be going on or what advice to provide. Here's where you should go. Maybe there needs to be documentation. The other thing is, the congressman would need permission to launch an inquiry if it had to do with an individual person. So, they would have to have some permission signed by them that they could investigate their situation.

Berkowitz:

Did you also do work on things other than casework, such as preparing testimony for someone that had to speak before Congress?

Desmarais:

Not at that point. There was a whole section in the Office of Legislation that was more involved in working with Congress and the testimony side. So, not when I first joined the agency. No.

Berkowitz:

I see. So, how did you get to be the Executive Associate Administrator?

Desmarais:

Well, first we've skipped over a bunch of things. From the Bureau, I was acting Deputy Administrator. At one point the Deputy Administrator left. They didn't permanently fill that job, and I held it in an acting capacity for a year and a half. And then when Carolyne Davis left as Administrator, there was another Acting Administrator for a period of time who was the right hand person for the Secretary. But then, he left, and that's when I took over as Acting Administrator. This was between Carolyne Davis and Bill Roper. When Bill Roper came, he asked me to stay on and to be what was considered the number three job, which was the Executive Associate Administrator. That position has not always existed.

Berkowitz:

Had you known Bill Roper when he was working in the White House?

Desmarais:

I had known him but not in depth. But I certainly had known him because of his position at the White House.

Berkowitz:

How about Carolyne Davis?

Desmarais:

I didn't know her when I joined the agency, but she is the one who had the final say in the agency about hiring me to join the Congressional Affairs staff.

Berkowitz:

What was the year that you went to HCFA, originally?

Desmarais:

I went to HCFA in 1983 and I stayed until February of 1987.

Berkowitz:

So, you had a four year career there, and in February of 1986, as I understand it, until May of 1986, you were the Acting Administrator. How did that appointment come about?

Desmarais:

They were still waiting to confirm Bill Roper, and the Acting Administrator -- I forget whether he had moved to another position or left -- but they needed somebody. And so, I was asked. At the time, Otis Bowen was the Secretary. I was approached about my willingness to be Acting Administrator until Bill Roper was confirmed. I agreed. It had a few exciting moments, but it wasn't a very long period.

Berkowitz:

Did Secretary Bowen recognize you as a fellow M.D.?

Desmarais:

I believe he was aware that I had an M.D., but whether it played an important role in his thinking, I don't know for sure.

Berkowitz:

So, you said that you had some exciting moments. What were some of those exciting things that happened?

Desmarais:

Well, the most exciting one was the forced release of the hospital mortality data. I vividly recall all of that, and it was one of those things that you don't prepare yourself for. You discover that there's something going on deep in the organization, and there's a Freedom of Information Act request and the General Counsel saying we have to release -- we have no choice. We organized ourselves to release it as responsibly as we could. I ended up going on MacNeil/Lehrer the day of its release.

Berkowitz:

That story became a *New York Times* story, March 1986, written by Joel Brinkley, who I believe was David Brinkley's son.

Desmarais:

[affirmative]

Berkowitz:

And the idea behind the story was that there's this database or set of numbers about various hospitals, and there was a comparison of the mortality rate at a particular hospital with the national average. Do I have that right?

Desmarais:

Yes. This was work that was going on within the Office of Research and Demonstrations, and Dr. Henry Krakauer, who's now deceased, was doing some analysis. It was reasonably preliminary and it's not as if we were planning to use the data in a regulatory way or release the data publicly or anything. But for one reason or another, that I can't recall or never knew, some reporters were aware of the information and demanded its release.

Berkowitz:

I guess that the downside of that would be that if someone knew that a particular hospital had this very high mortality rate, they might not go there. Is that the idea?

Desmarais:

Well, certainly, if you were a hospital, you wouldn't want to be identified as having a high mortality rate, and obviously one of the things that we did at the time the data were released is to try to explain that this wasn't a report card, that there were a lot of factors, that the risk adjustment was imperfect, and et cetera. But certainly, hospitals were concerned if they were at the high end of the scale.

Berkowitz:

Was it your decision to release this information?

Desmarais:

No. It was not my decision. The General Counsel told me I had no choice. Whether that was true or not is something I've often wondered about, but I was not the General Counsel. And this was made a legal matter. And I certainly did not want to go to jail so we released the data.

Berkowitz:

When you went on MacNeil/Lehrer to talk to the media, did you try to point out that this was just preliminary and not a report card and so on?

Desmarais:

In fact, those were my very words -- that this was not a report card on hospitals -- and we tried to explain what this was and what it wasn't and how it needed to be treated with care.

Berkowitz:

I wonder why there was such interest in the media in this story; was there something particular to that time?

Desmarais:

I suspect death, hospital mortality, is generally a big deal. I suppose, as well, prospective payment was relatively new still. There had been the issue of sicker and quicker discharges and hearings that had been held on that and so on, so.

Berkowitz:

So, if you could argue that this is the Reagan era's story, that the Reagan Administration in 1983 had put DRGs (diagnosis related groups) into operation, and -- because they're so concerned about money-- it had led to quicker releases from hospitals, which could lead to higher mortality and this might provide evidence of it. Would that be the chain?

Desmarais:

Could be. I wasn't among the reporters, but certainly, there had been hearings. And in fact, I had joined Carolyn Davis in hearings where the focus was whether there were quick earlier discharges. The terminology "quicker and sicker" was coined. I believe even Senator (John) Heinz (R-Penn) may have been one of the people involved in that. But since nearly all hospitals were subject to prospective payment, the fact that only some are at the higher end of the mortality scale makes it hard to make a causality case. I suspect the mortality data in and of themselves, even if you didn't have prospective payment, would have been of interest.

Berkowitz:

So, that was one issue that you worked on when you were at HCFA. Are there other things like that stick in your mind?

Desmarais:

No. Nothing like that. The rest of the time was mainly trying to make sure the trains were running and that regulations were being issued and that the work of the agency was ongoing. Obviously, three months is not a very long period of time, but nonetheless, it was an interesting experience.

Berkowitz:

So, just considering your work at HCFA, as a whole, did you have an agenda? I don't know, maybe having to do with improving the quality of care or making the payments more efficient or whatever. Were there other things that were themes of your time there at HCFA?

Desmarais:

Well, I think I'd have to be honest and say I was there as an Administration appointee, and that those above my pay grade were deciding the themes and were deciding the priorities. My job was really to do the best I could to make sure the agency was running properly. We certainly were concerned about costs; that was an issue that people were worried about. Quality was another issue as well and, of course, the whole Peer Review Organization program was involved at the time PPS came along.

Berkowitz:

Were nursing homes a sensitive area in terms of quality of care or how they contributed to long-term care or whatever?

Desmarais:

I have to say that while I was at the agency, I don't recall nursing homes being as high priority or as taking as much of my time as other issues were. Of course, it was a very busy time on the hospital payment side. The coverage of transplantation was another really hot topic, at the time.

Berkowitz:

So, it's a busy time on the hospital payment side. Why?

Desmarais:

Well, because it was the early days of the prospective payment, and like any new program, there was a lot of activity on the policy making adjustments and changes in regulations that were coming out each year. And then at the time, all the initial work was being done on the physician payment reforms that ultimately emerged in the relative value system. But that was all being done out of the Office of Research and Demonstrations.

Berkowitz:

So, were you in some sense an advocate of prospective payment? Did you agree with - the implementation of DRGs to pay hospitals? Or did you think, maybe, that there could have been a better approach?

Desmarais:

I don't recall having any problems with it. But again, before I joined the agency, the decision had been made that prospective payment was where the agency was going and Health and Human Services Secretary (Richard) Schweiker issued a report in December of 1982, which was a report to Congress about the whole prospective payment system. By the time I was in a regulatory role, Congress had passed the law and we were implementing it.

Berkowitz:

As I recall, that was passed in 1983 as part of the same legislation that was the social security rescue legislation.

Desmarais:

Correct.

Berkowitz:

Someone had the idea of putting DRGs into law as part of that legislation. Do you know anything about that?

Desmarais:

I wasn't intimately involved in the legislative consideration. No.

Berkowitz:

So, you eventually left HCFA, and that was still the 1980s, and you went to Health Policy Alternatives?

Desmarais:

For the first time. Yes [affirmative].

Berkowitz:

Can you tell me a little bit about that organization?

Desmarais:

Yes. It was founded in 1978 by three individuals who'd worked in the government. Their model was the Congressional Research Service. They wanted to create a small firm that would provide nonpartisan, technically competent assistance to a wide range of organizations, without really being lobbyists. They were not interested in being lobbyists. They really wanted to provide technical support, analytic support, understanding, of course, that the folks they were assisting, which could include various provider organizations and others, would be advocating both on Capitol Hill and within the regulatory process. But they wanted to be the behind the scenes people who could assist in those efforts.

We have a wide range of clients that span the full spectrum, everything from the consumer perspective to the provider perspective to the drug and device manufacturer, the payer perspective -- just about anybody who has any interest whatsoever in health care. We certainly have played a role with those types of organizations, and so, I was there the first time from 1987 to 1998.

Berkowitz:

That's a period of time when the Institute of Medicine (IOM) was trying very hard to establish itself, trying very hard to get mentioned in congressional reports, being asked to do a report on something. Yours was a different kind of an organization?

Desmarais:

Well, one major difference is that the IOM speaks very publicly. So, they will put out a written report that's in the news saying "IOM recommended XYZ." You won't find a Health Policy Alternatives report that recommends XYZ that's in the public domain. We don't operate quite in that way.

Berkowitz:

So, you're not advocates. You're trying to improve the whole conversation?

Desmarais:

Exactly. And I think that among the roles that we can play, is making sure that a particular client is not operating in a silo. One of the jobs I think we have is to make sure we tell them when the emperor has no clothes. We make sure we tell them that there is, believe it or not, another perspective than the one that that organization might have. And we explain, if they're interested in a particular policy, that they might have to compromise or acknowledge other perspectives and accommodate them in some way.

Berkowitz:

I came across this case recently in which a big pharmaceutical company was making a wheelchair, and it was expensive. The question came up, "Can this be reimbursed by

Medicare as a piece of durable medical equipment?” Is that the sort of thing you might do? Or is that too inside, too proprietary to a company?

Desmarais:

No, it's not too inside a question. There are legitimate questions regarding how a new health product or service will be coded. Coding and Medicare coverage are areas we would investigate with clients who have that need. Is it safe and effective and what evidence is required? And then, there are questions about reimbursement. Depending on where the product or service is used, it can trigger all kinds of questions about is this part of the nursing home's payment? Is this part of the physician's payment? It often might be that they have a concern or an issue that is going to require legislative action.

One of my partners here, an attorney, might actually draft a bill or an amendment that they could then approach a member of Congress and see if he or she would be interested. We might be also helping them with testimony if need be, or helping them with handout materials that might help make their case. But in terms of being their representative or their spokesperson or trying to open doors for them on Capitol Hill, we really don't do that.

If you Google us, you'll see that we have filed under the Lobbying Disclosure Act, but that is because we've taken an extremely conservative perspective, historically. If one of us goes to the Hill and has a meeting, just to talk about why a bill is drafted in the way it is or serve as a technical resource, we count that as a lobbying contact. And so, we've at times had to file under the Lobbying Disclosure Act. But it's not common, and currently, I believe we're not filed for any client because we've been trying to studiously avoid any lobbying contacts.

Berkowitz:

Did you have a specialty within the organization?

Desmarais:

Coding was one of them because when I was in the government I sat on the American Medical Association's CPT (Current Procedure Technology) Editorial Panel for three years. I've got a fair expertise on the coding side of things. My expertise includes coverage and payment; I've been very involved with competitive bidding for durable medical equipment type issues. I've been very involved with electronic health records, meaningful use issues and telehealth issues. So I've got a set of issues I tend to work on here, and as do all my partners. We try to focus on certain types of issues.

Berkowitz:

Telehealth. Does that mean that I'm in Fairbanks, Alaska and I talk to a doctor in Seattle?

Desmarais:

It can mean a lot of things. The definition is not nailed down, but Medicare has a very specific definition which is narrower than the definition used by many other people when they use the word "telehealth." But certainly, what you were describing is one form of telehealth where you've got real time audio visual communication with the physician being in one place and the patient being in another place.

Berkowitz:

Does that extend to surgery? Can you do surgery by telephone?

Desmarais:

As you may know, there has been robotic surgery done that way.

Berkowitz:

That seems an unexplored world?

Desmarais:

Well, it's explored, but it's not a part of the Medicare definition of telehealth so it's not a covered service.

Berkowitz:

You worked for a fair amount of time at Health Policy Alternatives -- more than a decade -- between 1987 and 1998. Afterwards you did some other Washington work for different organizations. One of which was the American College of Surgeons. How did that come about?

Desmarais:

The American College of Surgeons was one of our clients, and they were undergoing a leadership change and also one of the people who had headed up their policy shop was retiring. One thing led to another, and I was offered to replace that individual. I decided that I wanted a change of scenery, as they say. And so, I joined that organization. I actually had an office here in Washington in Georgetown, which is where their Washington office was. But I also had an office in Chicago. I was in Chicago a fair amount and half my staff was in Chicago. I used to joke I also had an office on United Airlines. [laughter]

Berkowitz:

And the reason they're in Chicago is they want to be close to the AMA?

Desmarais:

I believe, historically, that's probably the case, but that's where their headquarters are. Yes.

Berkowitz:

And just so I understand, the American College of Surgeons -- are they the organization that that helps to license that specialty? Or do they have another job?

Desmarais:

There's a board. There's the American Board of Surgery, which is separate, but the American College of Surgeons is a membership organization made up of surgeons. It has prided itself on focusing on quality issues, historically. Also, things like developing various guidelines for trauma care. They've also been very actively involved in the whole cancer registry world. They've got a long, long, long history of being involved in various quality-type issues, but they represent the surgical profession -- in particular, the general surgeon.

Berkowitz:

Were you working on these particular issues that you'd mentioned, for them?

Desmarais:

Sure. Our job was basically the policy end of it--relations with the Congress, relations with the various agencies.

Berkowitz:

Would they comment on things like transplants? There was a big question about transplants when they were first done. What should be the attitude of the medical profession toward them? Is that the kind of thing they would talk about?

Desmarais:

I don't recall that specifically. But, for example, they've taken positions on the wearing of helmets for motorcyclists. They have taken positions on what types of equipment should be available or safety issues dealing with the practice of surgery or that a surgeon shouldn't be an itinerant surgeon, that the surgeon's really responsible for preoperative care, postoperative care, et cetera. In addition, there are more formal policy statements the Board of Regents would issue, but the College would certainly testify or the College would have other positions that they would take on federal legislation or regulations.

Berkowitz:

At some point, you also worked for the HIAA -- the Health Insurance Association of America. When did that happen?

Desmarais:

Let's see -- I think it was probably 2000 when I went to the Health Insurance Association of America.

It doesn't exist now because it merged with another association. Karen Ignagni, who just announced she's going to be leaving, heads up what in effect is a merged organization, and HIAA was one component of that organization. And the merger took place, I think, in 2003.

Berkowitz:

And when you got to HIAA, was Chip Kahn the head?

Desmarais:

Chip Kahn was still the head. Although, he didn't stay very long after I joined the organization.

Berkowitz:

Did he hire you?

Desmarais:

Yes. He had worked on Capitol Hill on the Ways and Means Committee.

Berkowitz:

Is that how you got to know him?

Desmarais:

Right. We had intersected during my Hill days, as I recall.

Berkowitz:

What was the job you had there?

Desmarais:

Senior Vice President for Policy. I was doing the policy work, which supported both the state government affairs people as well as the federal government affairs people. We had a very active state governmental affairs shop. It wasn't part of my office, but a lot of the lobbying of HIAA took place at the state level.

We were more the policy people so we were the ones developing the testimony if HIAA was going to testify or we staffed a number of committees. There are a number of different committees. You hear health and you think that's one product line. But there could be a dental component, a disability insurance component, or long-term care insurance. There was reinsurance, and there were all these different committees that were the policy-making arms of the organization, with member companies on each of these committees. They would have an agenda, like all committees, and develop positions and recommendations for the organization as a whole.

Berkowitz:

Did you see much feedback between the private insurance industries and, say, Medicare? Sometimes, for example, the private insurers have a bad year, in terms of profits and returns, and that reflects larger trends in health care financing. Did you observe things like that?

Desmarais:

I guess I would say it differently. I think that all payers face very similar issues, and how they approach them may differ. Sometimes Medicare is in the lead, and the private sector is following. But in the other times, it's the private sector that's leading and Medicare catches up later. But certainly, there needs to be a good understanding of and paying attention to what's going on in the public sector as well as what may be going on in the private sector. In addition, one of the product lines is Medigap insurance, and so naturally, those people are very interested in what Medicare is or isn't doing.

Berkowitz:

You worked at HIAA until about 2004, and then you went back to Health Policy Alternatives?

Desmarais:

Well, not immediately, but the story, as I like to say -- when the merger took place, I described it as HIAA being acquired. The senior staff did not do very well during the acquisition process. So, at that point, I was what they call unemployed, with a nice severance, but unemployed. So, began a job search and long story short, I ended up coming back to this organization which fortunately needed a lot of extra help because of demand for the work.

Berkowitz:

You're still working there now?

Desmarais:

I announced my retirement yesterday.

Berkowitz:

Wow. Congratulations. When will be your retirement date?

Desmarais:

June 30th.

Berkowitz:

You've certainly had a long run in this health care field from Yale Medical School through HCFA through all those other influential organizations. As you think about this -- on your retirement date or as you near retirement, do you have feelings about what should happen -- what the future of Medicare and Medicaid might be?

Desmarais:

I think it's a broader question, really. It's really what should the health care system look like? Sometimes I try to put my consumer hat on and see my own personal experiences and those of my family and to think about how it could be better and then to go from there to think about how could the federal policy facilitate some of that. These are all very debatable issues. I've got clients who probably have a dozen different opinions about any topic that we could talk about on this call.

Berkowitz:

One of the things that one hears is that Medicare can't be just processing claims; there has to be a better way -- finding some payment mechanism that rewards quality, for example. Is that a question that you've been working on?

Desmarais:

Certainly -- from the value modifier perspective and even going further back with various pay for performance programs and so on. What they're finding out with the value modifier is there is a danger of mischaracterizing whose high quality and whose low quality, due to the way you measure, due to the limitations of risk adjustment. The question you always have to ask yourself is "Are you really rewarding quality?" Said another way, if you're penalizing providers, are you penalizing the right people or the wrong people?

In addition, there are the weaknesses in the measures. I've seen a lot of measures that I would wonder whether they're truly important. They're there in part because every specialty wants measures because they need them; otherwise, they're going to be penalized. And yet we don't have a lot of good outcome measures. I think the concept makes sense; it's just how you operationalize it that is a problem; I think, we're still learning.

Berkowitz:

Thank you very much for doing this. Your career is a very interesting one so we really do appreciate your taking the time to do this.

Desmarais: Thank you.

Interview with Charlene Frizzera

Washington, DC on May 7, 2015

Interviewed by Edward Berkowitz

Transcript edited for clarity.

Berkowitz:

Today is May 7, 2015. We are in Washington DC, talking to Charlene Frizzera at her office on Capitol Hill.

I'd like to talk about your work at CMS. Before we do that, please tell me how you got to CMS.

Frizzera:

Sure. When I graduated from high school I got a letter from the IRS for a secretarial position. I took the job and worked there for about seven years. I started as a secretary but by the time I left I was an accountant. CMS -- HCFA at the time -- was hiring accountants to audit cost reports for big chain providers. So a lot of folks who worked at the IRS said, "Wow, we're all going to go to HCFA. This sounds like a cool job." We were there about a year and a half, and they decided they were going to contract that function out so we all had to find jobs.

There were no real accounting jobs at HCFA at the time; all of that was done by contractors. Fortunately, a friend of mine worked in Medicaid reimbursement and he said, "Do you want to come here?" and I thought, "Okay. I need a job." And that's what I did. I went to work in Medicaid. It was such a great opportunity because I got to go from lines and double lines to actually reading regulations and writing regulations and understanding the Medicaid program.

Berkowitz:

Did you grow up in Baltimore?

Frizzera:

Yes.

Berkowitz:

Where did you go to high school?

Frizzera:

I went to Kenwood High School.

Berkowitz:

I guess HCFA was in Woodlawn at the time?

Frizzera:

Yes. We had offices in the same building as the Social Security Administration.

Berkowitz:

When you entered the government service you must have been a fairly low GS level.

Frizzera:

I was a GS-2. I don't know if they even had GS-1s but I was proud I wasn't a 1. [laughs]

Berkowitz:

And you retired from the Senior Executive Service?

Frizzera:

I did. I retired in the Senior Executive Service, thirty eight years later.

Berkowitz:

Wow. Let's go through this career a bit. I see that you had lots of jobs at CMS and HCFA. I know you were a Regional Administrator in Philadelphia under Nancy-Ann DeParle and Director of the Medicaid and CHIP programs under Tom Scully, the Chief Operating Officer under Mark McClellan and eventually the Acting Administrator. Was there a key job that got you to the upper echelons of the agency?

Frizzera:

Yes. The Regional Administrator in the Philadelphia Regional Office retired and I was asked to do a temporary detail in the position until they selected a permanent Regional Administrator. I was working in the Medicaid Bureau and the leadership encouraged me to do the detail.

They said I have a reputation of knowing how to get things done and since the Regional Office position was managing the operations of the Medicare and Medicaid programs, they thought it would provide good experience. It wasn't a promotion and it was only supposed to be 90 days, so I took a chance. I took the chance and the leaders took a chance on me.

Leading a regional office is different than being a leader in the main campus. You are expected to lead and manage the office without interacting daily with the Baltimore and DC leaders. We had about 150 people in Philadelphia, which was a big job for me. I'd never managed that many people so it was really a great place for me to figure out how to run an organization: how do you do budgets? How do you do H.R.? How do you make sure the work gets done? When they posted the job at the end of my detail, I applied and was selected. That job gave me the confidence to enter the Senior Executive Service.

Berkowitz:

Which states did that regional office deal with? Pennsylvania I would guess.

Frizzera:

Pennsylvania, Maryland, Delaware, Virginia, West Virginia, and D.C.

Berkowitz:

What did you spend most of your time on? Medicaid or Medicare issues?

Frizzera:

We spent most of our time doing outreach, so most of it was meeting with providers from both sides of the program. We had a lot of meeting with states, meeting with the MAC contractors. I always describe those jobs as really the eyes and ears of CMS or HCFA. Everybody in that region sees you as CMS. So it's a lot of interacting with providers, beneficiaries, and contractors.

Berkowitz:

Did you get involved in any political interactions with political leaders?

Frizzera:

Very little. We didn't really get involved in the policy decisions. Somebody decided what the policy was and then our job was to perform audits, on-site reviews and provider and beneficiary education.

We did a lot of survey and certification work. Each regional office is responsible for surveying nursing homes in those regions, which was a substantial workload. When I was asked to explain to people what one did in the regional office, I would tell them all kinds of stuff and as soon as I said, "We survey nursing homes," people got that. That was real, they understood. It was something people could visualize. And it was really a tough job.

Berkowitz:

Earlier you were talking about cost reports. Were you referring to hospital cost reports?

Frizzera:

In the old days there were cost reports for everything. Hospitals, skilled nursing facilities, home health, hospice, everybody had a cost report because that's how providers got paid. If you didn't fill out the report, you didn't get paid.

There are still cost reports. But the development of prospective payment systems such as DRGS for hospitals and the growth of managed care systems has really lessened the importance of cost reports for individual provider payments. But when I started doing that job that's how they got paid. We wrote a check at the end of the year, or they wrote us a check, for the difference between what we gave them during the year as up-front payments, and their actual cost at the end.

Berkowitz:

Interesting. So what brought you back to the central office?

Frizzera:

We were going to have to move. I had told my husband and my son, "I'm going to take this job but we have to move eventually." And they said, "Okay, that sounds fun." But then I said, "Now we've got to move." And they said, "We don't really want to move."

My son was in high school in Baltimore, so moving to Philadelphia wasn't ideal.

Fortunately, Tim Westmoreland was the Medicaid Director at the time, and he said, “We’d love for you to come back. Do you have any interest in coming back to Baltimore?” He asked me if I would come back and be his deputy in the Medicaid program. That couldn’t have been better timing for me.

Berkowitz:

So your first job back was Deputy Director of Medicaid and CHIP. What was that like? To whom did you report?

Frizzera:

I reported to Tim Westmoreland. The job of all of the deputy directors that worked directly for a political appointee is really to take the political agenda that the political appointees put on the table and help the organization understand what that is, and make sure that they follow that agenda. Your job really is more day to day managing and running the program. We make sure to get the right issues to the decision makers, and make decisions on issues that don’t have to go higher up the line. The political appointee’s spend more of their time with the political staff and the Department appointees ensuring everyone is kept abreast of the organization decisions.

Berkowitz:

I see. What were some of the big issues of Medicaid at the time?

Frizzera:

I would just say a consistent issue is always funding and financing. That means issues like provider taxes and donations, issues like disproportionate share.

The difference I find between Democratic leaders and Republican leaders is their vision of how much they need to control the program. Tim, for example, had very strong beliefs on how a state should provide services to children. So we spent a lot of time with how he thought the children’s health program should work. We spent time working with states to try to get them to understand what they could do with the money, giving them best practices and ideas on how they could run the programs a little bit better.

I think many of the issues at that time were really around the Children’s Health Insurance Program and for what I would call special needs people--people who didn’t easily fit in generic Medicaid. That would include people with HIV/AIDS, people with severe disabilities; they were a pretty big part of the agenda for that administration.

Berkowitz:

How would they be handled differently, people with severe disabilities?

Frizzera:

There are a couple of issues. States are allowed to have waivers in the Medicaid program. The basic law, without waiver, says if you provide a Medicaid service to one person you have to provide it to all on Medicaid. That administration started talking about how to find a way to allow states to carve out populations and have special services and programs for them that everybody else in the state didn’t have to receive—to get waivers that would allow that.

Berkowitz:

I see. Was the CHIP program viewed as an extension of Medicaid? Was the state bureaucracy that handled Medicaid the same one that handled CHIP?

Frizzera:

Usually not; usually it was a separate agency. Some of the people doing the work came more from child protective services, people who had actually dealt more with children's issues. The other reason it was separate is the financing was really different. In the Medicaid program it's part federal, part state financing. The CHIP program didn't work that way. The federal government provides an allotment to the states if it agreed to meet certain requirements. The states had a lot of flexibility on how to use the money. It was really a very different program from Medicaid.

We didn't have as much oversight in the CHIP program as we did with the Medicaid. And at the time it seemed very important to Medicaid agencies to make sure that it wasn't seen as Medicaid so that children would sign up for it. They were very afraid that if they said it's Medicaid people wouldn't sign up for the program, so we did a lot of work to make sure that it wasn't considered Medicaid. It's a separate program just for children.

Berkowitz:

As you got into this fairly visible job as Deputy Director, were you still pretty shielded from the political side?

Frizzera:

The deputy directors are not shielded, the agency is shielded. So, I didn't go to political meetings, but I knew what the political agenda was. It's really important because one of the big differences between a political appointee and a senior executive service leader is this, as we would tell the politicals, "You realize that if I have to testify and put my hand on a Bible, I will have to tell the truth, the whole truth and nothing but the truth. You don't want to put me in a position nor do I want to be in a position where that would be uncomfortable." So I would never want to have to go and say, "Somebody told me to do it because they needed a vote on a bill."

Instead, I would get a request such as: "We want to figure this out: can we do something to expedite the approval of the New Jersey waiver?" I didn't know what the circumstances were. I didn't ask questions, but I made sure that we could do it legitimately. So one gets direction but is not really in political meetings where they actually talk politics. I had a different role. The political people would come and say, "Here's what we want to do. Can we do it?"

Berkowitz:

I see. You said that you kind of knew what the political agenda was. What was political agenda with Tom Scully, for example?

Frizzera:

With, Scully -- [laughs] -- it was very interesting.

I'm not a very good writer, I'm a bullet person, but if I could write a book I think it would be very interesting to look at the dynamics of the agency for each Administrator and their impact on how the agency changed.

Bruce Vladeck was the first Administrator that I actually worked with. Bruce brought academia to CMS. Before that we really were a claims processing organization, more operational. Bruce brought policy analysis and academic thinking to the agency. He reorganized the agency and really brought a whole new breadth of people and experience and responsibilities to CMS.

What Bruce didn't really like to do was the operational stuff. So he didn't like the Hill; he didn't like working for the Office of Management and Budget; he didn't like the Office of the Inspector General or the General Accountability Office. To an academic, it's like that's all just chatter. If some of those operational detail people came in and said, "You're not doing things right," that was just chatter to him because that wasn't his world.

Nancy-Ann came in, and Nancy-Ann had a lot of health care experience. She worked at OMB so she had a solid understanding of the "bureaucracy" of the government. Before that, she worked at the Tennessee Medicaid program. She came in, and she was very operational. She came in and took over saying, "Okay, some of this is a mess. We've really got to get all of this stuff together." She built really great relationships between outside entities -- I'll call them -- and CMS.

She had the Balanced Budget Act of 1997 to implement which was big at the time. When I look back, I remember we were horrified by the BBA. "Oh, my gosh, how are we ever going to implement that?" It was a huge piece of legislation to implement and Nancy-Ann really did a fabulous job of getting that legislation implemented and managed so that we could have successes.

Tom Scully came in then, and he came with the vision that CMS needed to be more friendly and more open, based on his experiences. He saw it as too much of a closed system that didn't really help people as much as it should. The staff at CMS didn't talk to external entities/organizations.

So he did a fabulous job of really opening the agency up. He created these open door forums that still exist today. The open door forums were so successful because Tom would get on the calls, and they were open to anybody who wanted to call in. Imagine a government agency -- and somebody brave enough, really -- to say anybody who wants to call, call. We'll take any questions.

Berkowitz:

Including from patients?

Frizzera:

Yes, anybody. It was an open phone line. They published the number in all kinds of places and thousands of people would call into those phone lines. He just did a great job. Tom's very candid. He would get on and he would be honest and talk about issues and really dealt with problems.

He also spent tons of his time getting the Medicare Modernization Act (MMA) passed, which was the second huge piece of legislation. He did a lot. He did a lot of the relationship work for CMS for MMA; he was on the Hill, talking to providers and organizations – he was everywhere. And then when MMA got passed, Tom said, “Okay, my job is done.” And then Mark McClellan came in.

Berkowitz:

And McClellan brought both an academic and an operations perspective?

Frizzera:

Mark is a physician with credentials from MIT, Oxford, and I think some other impressive places. He’s an incredibly bright strategist who really “gets” healthcare. Put on top of that that his job was to implement the biggest legislation we had ever seen up to then.

There are people who are good strategists. There are people who are good politicians. There aren’t a lot of people who are really good strategists and also can sit down at a table and work through a plan, how do I get from A to B?

We spent all of our time working very hard with incredible influence and help from Mark and that was a very risky legislation for us, the Part D program particularly. If you think about it, it was the first time CMS had to sell a product. We were regulators. We wrote rules and people followed them. This Part D legislation was really different. We had to find plans that would offer the services. We had to find beneficiaries who would sign up for it. That was a totally different responsibility than CMS had ever had.

So we became a marketing machine. We had our ten regional offices -- literally in every regional office they had a room with maps down by zip codes and we would tag numbers: how many people we talked to, how many people we got to sign up. It was a gigantic campaign to get beneficiaries to sign up for Part D, and a ton of negotiation with plans to get them to do that. So it really totally changed the agency. You can imagine in doing that there’s a ton of risk in systems, in budget. There are a lot of operational risks.

Typically, bureaucrats are generally risk-adverse people. At first when we would brief Mark we’d recommend the least risky option. We decided that’s not really the way to do it. We then would give him all the options from the highest risk – with why we thought it was risky -- to the lowest risk.

The beauty of working for Mark -- he said to hundreds of people sitting in these meetings, “Your job is to give me the best information and make sure you give me everything I need to know to make a decision. I take full responsibility for the decision. So if it doesn’t work it’s not your fault, it’s mine.” And he sometimes made very risky decisions. But people felt very loyal to him, and they felt loyal to the program. I will say I think that people in CMS were super, super, super proud of what they did at that time. People just had this great pride.

People made up buttons to wear and did videos and were sharing pictures. It was just an incredible moment for CMS to really reconnect with the purpose of it all. Why do we get up

every day? For beneficiaries. How many people in CMS ever really see a beneficiary? Everybody in CMS saw a beneficiary somewhere along the line in this effort. I don't know if you remember we had the big bus to help spread the word about Part D. People got to meet the President of the United States. How often does that happen?

To me, it was a magical time at CMS and Mark was really a great leader -- the best person to lead that vision because it was very difficult and very risky.

Berkowitz:

So, just let me see if I can understand that about this Part D. It's a little bit like Part B, since that actually had to be sold too. But with Part D, wouldn't the plan, the prescription plan, have a desire to sell it too?

Frizzera:

Yes. That's true. But the law had a lot of requirements on CMS regarding what you had to do in the Part D program. We thought it was really important that it was a brand new benefit, and we wanted to make sure beneficiaries understood it.

So the challenge was first understanding it. And then-- I guess "selling it" may be a little too aggressive, but it was really educating beneficiaries saying, "Here's the benefit and what this does for you." It was such an extraordinary benefit that nobody could believe it was true. When you look at what the Part D drug program did for prescription drug coverage in America, it's unbelievable. So we felt our job was to make sure people really understood it and not just got a sales pitch from a plan.

Berkowitz:

So how do you do that? It seems like kind of a slippery line there. You wouldn't tell somebody she should pick this plan and not that plan, right?

Frizzera:

Exactly, right. That we didn't do. We did say: this is what this benefit does for you. Here are all of the opportunities you're going to have. We did a lot of work on educating beneficiaries about what was important in picking a plan, and CMS did what we call the "tool finder." It was the first time, again, we ever did this kind of intervention. We designed a computer tool that beneficiaries could use by inputting their current drug needs. The tool would then present a list of the plans that would be able to help the beneficiary, based on the benefits that the plans offered, with the different cost to the beneficiary of each plan.

Berkowitz:

And you were pretty confident that a 67-year-old person would be able to handle that?

Frizzera:

It was pretty easy. But another thing that we did that we had never done before was engage lots and lots and lots of partners. We had thousands of partners helping us educate beneficiaries.

Before MMA passed, you could not use the Medicare logo unless this small group of people approved your material. It was something like 15 people. We realized that

approach was impossible with Part D. You have to let other partners use the CMS logo when they distribute the material. You need to let other partners speak for CMS. It was a giant education campaign to educate the partners, and the one thing we really wanted to make sure is that the material that beneficiaries got was the same from everybody. So we worked a lot with partners to develop some good standard material that everybody could use because we wanted to make sure the message was the same.

We worked with all kinds of people that we thought would be the best source of trust for the beneficiaries. We sent material to churches, to schools; we talked to children in high school about their grandparents. We reached an unbelievable number of people. Anybody that we thought would be able to understand and support the program for people who needed it, we would reach out to them. The big change was this permission we gave to thousands of people to speak on behalf of CMS for the program.

Again, the education of beneficiaries was not to sell them a United Plan or an Aetna plan, but just to get them to understand what the benefit was.

Berkowitz:

I see. I think I read somewhere that when Mark McClellan was talking about this to some sort of national audience he said, "What you should do is take all your pills out and see what they are and then make sure that those pills are covered by your plan."

Frizzera:

Exactly. That's what the "plan finder" would do. Beneficiaries could use it on their own or someone could help them. There were people who were recruited to help with this.

Berkowitz:

Did you expect people to be able to decide whether they needed the brand name drug or the generic?

Frizzera:

No. That's ultimately for physicians to help decide. We were educating beneficiaries about brand versus generic drugs. What is that? Many didn't even know what that is. It was interesting when we started educating beneficiaries how educated they became and how much they started asking questions about their medications like "Why do I get that?"

Now we have the Area Agencies on Aging -- triple A's -- and the State Health Insurance Programs -- the SHIPs -- who go out and help beneficiaries all the time with Part D and other Medicare choices.

Berkowitz:

I see. I wanted to pick up also on some of the things you were saying about the various administrators.

As you said, Bruce was an academic come to government. I've heard him talk a lot about making the place customer friendly and that sort of thing. You didn't ascribe that to him; you ascribed it to the later Administrator, Tom Scully?

Frizzera:

Yes. I think what Bruce did was make the organization easier for people to understand. Before he re-organized HCFA, it was pretty hard to know who did what. The names of the areas were not transparent of their responsibilities.

Bruce said, "Here's the new deal. We're going to have centers and we're going to have offices. Centers do policy. Offices do operations. So, if somebody wants to come to CMS and talk about a Medicare policy you're going to go to the Center for Medicare. You don't have to worry about all of these other places and it's all going to be in one spot. So this center does all the Medicare stuff. This other center does all the Medicaid stuff." And those were the positions that were political appointees. The offices were not political appointees.

So I think Bruce made it consumer friendly in the sense that you suddenly could understand the organization. I would say if Tom hadn't come along and did what he did -- I would say Bruce made it customer friendly. Yes, he did make it more customer friendly than it was, but then Tom came along and really made it more customer friendly. I would say he built off of Bruce's vision that it's hard to figure out what CMS is about. Bruce's idea was to reorganize the organization and that was a big deal. It took a lot of work and a lot of effort to make that really happen. You just don't draw up papers and send them in and hope change works.

It was a very thoughtful process. For example, he combined several functions into the Center for State Operations. The idea was Medicaid survey and certification, anything that dealt with the state, was in that bucket. It was a little difficult to transition because survey and certification is also Medicare. But his idea was that states needed to know, "Anything you have to do with CMS, you go to this box. You go to the Center for State Operations."

So, he did make it more consumer friendly in the sense that he organized it in a way that people could understand better what CMS did and where they should interact with people.

Berkowitz:

I see. Talking about Mr. Scully for a moment, you said that he took on all these phone calls?

Frizzera:

Yes.

Berkowitz:

Ordinarily, when they do shows like that on television they have a producer or somebody screening the calls carefully. If Mr. Scully took calls directly, would he get calls like, "My wife is sick with such and such and we've been having a hard time with the billing for Medicare. I can't understand this stuff." Would he get or take calls like that?

Frizzera:

Yes. The thing about working for Tom, for me was I thought he was fun to work for. I think he scared a lot of people to death. He scared the communications people. I think he probably scared his General Council some days because Tom felt like if you're honest and

open with people everything will work out. So he would get on these calls; they were run by an operator, but they didn't screen the calls. It was basically, "We have a call from Bruce in Iowa." And Tom would take whatever questions people had. But Tom never found that scary. He didn't even think it was risky. He would say, "Well, if somebody calls and they have a problem, we should deal with it. If we've done the best we can, then we need to tell them 'I'm sorry, we've done everything we can for you'."

So, he wasn't afraid. He really felt like that was what CMS was supposed to do. We weren't supposed to hide. We were supposed to take the tough questions, deal with the tough issues, open and honestly and not hide under "We'll call you later."

Berkowitz:

I see. How did you get to this even higher level as chief operating officer? How did that come about? That was with Mark (McClellan)?

Frizzera:

Yes, that was with Mark. Before MMA, the chief operating officer at CMS was the Deputy Administrator. All the offices that I talked about before like the office of finance, the office of information systems, the office of human resources -- they didn't really need anybody to operate them. They were fine. They did their thing, and they reported directly to the Administrator.

But when MMA was passed it was so huge and different from any of the other legislation. In order to be successful you had to combine policy and operations. You couldn't let the policy people do their thing and when they were done send it over to the operations people where they would say, "Okay, I have money or I don't have money; I can design a system or I can't design a system." The timeline was just too short and the stuff was too hard. So Mark said, "I really need a chief operating officer. I need somebody to bring those people together and put together a real timeline, get decisions made in this agency and move forward."

The job was bringing all of the people who had to be a part of a decision working in a group; we made the decision together. We didn't give it to one and then hand it off to the other. We literally had these giant meetings with giant discussions about what the issue was. At the end of the day, the end of the week, we left with a decision that everybody agreed to. We had not just the policy decision but who's going to pay for it, what are the systems we need to do, and a plan at the end that gave people responsibility and a timeline.

As you can imagine, we had these gigantic project plans, and that was the function of the Chief Operating Officer. Originally John Dyer was the first Chief Operating Officer and he had a lot of experience.

Berkowitz:

Is that a presidential appointment?

Frizzera:

It was not. One of the ideas was it should be the highest career person. The idea was that you need somebody who is the person of whom it could be said “Here is someone who really made the agency work and should be the person that stays through administrations.” John came, and he had a ton of experience. He did a lot of big, big stuff at SSA. He worked for SAIC (Science Applications International Corporation), so he really did know how to do big project management; big visioning on how to get from A to Z. He did it for about a year and a half and then he left I was John’s Deputy and then when John left I became the Chief Operating Officer for the remaining five years.

Berkowitz:

So were you still pretty protected from the political side in that position?

Frizzera:

Yes. So again, Mark would say, “Okay, here’s what we’re doing. Here’s the decision. You guys need to make it work.

Berkowitz:

I see. Three laws that we’ve had in recent times that have been big for CMS are the Balanced Budget Act of 1997, the Medicare Modernization Act, and the Affordable Care Act.

The Balanced Budget Act of 1997 did many things. What is it that stands out about that from your time at CMS?

Frizzera:

The biggest change was the largest reduction in spending in 15 years for both the Medicare and Medicaid program. There were many provider payment reduction provisions, but the legislation also expanded the use of managed care in both the Medicare and Medicaid programs.

Berkowitz:

Could you give me an example of that?

Frizzera:

For the Medicare program, the legislation created the Medicare+Choice program which gave beneficiaries more health care delivery options. Beneficiaries could stay in the existing fee-for-service Medicare program or enroll in health maintenance organizations, point-of-service plans, or new types of plans, including preferred provider organizations, provider sponsored organizations, and private fee-for-service plans. The act also permits managed care plans to enroll only Medicare beneficiaries, and institutes new quality standards.

For Medicaid, the legislation provided an expansion in state authority with respect to the use of managed care. It enabled states to require most Medicaid beneficiaries to enroll in managed care without obtaining a waiver. These provisions had a significant impact on hospitals, physicians, and health centers from which low-income families have traditionally obtained needed care.

Berkowitz:

How about the Medicare Modernization Act? We know it brought Part D. Was there anything else in particular that you remember from your time there?

Frizzera:

The MMA brought changes with both Part C and D. Under Part C, it really reengineered the Medicare Advantage world. It put in new requirements, new rules, offered new services. MMA was another step away from previously conventional fee for service. Changing the details of fee for service Medicare reimbursement alone wasn't sufficient for changing the incentives in the system to get the best quality and value.

Berkowitz:

Even with DRGs?

Frizzera:

So the thing about DRGs, and I would say this is pretty typical whether it's a DRG, a bundled payment or anything that takes money and puts it in a bucket, providers figure out how to maximize the payments. The DRG system has lost some of its effectiveness. Hospitals know now how to maximize payments under the system; not cheating but delivering health care is a way that maximizes reimbursement. The DRG system changed not only how hospitals are paid but how they deliver care. It saved a lot of money. It was revolutionary, but now it's time to move on and think about healthcare delivery a bit differently.

Another thing about the MMA that I mentioned before but will mention again is that there was a lot beneficiary education in MMA that we never had before. The law included provisions about CMS' responsibility to educate beneficiaries about the programs. That was new. We didn't have a lot of that before.

Berkowitz:

We should talk about your time as Acting Administrator, also. It was actually a fairly large amount of time -- from January of 2009 until October of 2010.

Frizzera:

It was really April of 2010 when I stopped being Acting Administrator. I left in October. Don Berwick and Marilyn (Tavenner) came in in April. I stayed from April until October to help them transition and clean up some loose ends. It was from January 2009 until about April of 2010 I was Acting Administrator.

Berkowitz:

And where were we with the ACA at the time? It had passed, right?

Frizzera:

The ACA passed in March of 2010.

Berkowitz:

I see. So you're the Acting Administrator at that time. You must have been a little closer to the political activity?

Frizzera:

This is a great story. If you remember, Tom Daschle was going to come and be Secretary, and he had all these people on his list of who was coming to the Department. We didn't know who they were. They just kept saying, "Don't worry, in 60, 90 days it will be settled." So I agreed that I would stay until the next Administrator was confirmed. I was going to retire and they said "The one caveat is that you have to stay until the new Administrator is confirmed... We can't have one Acting and then another Acting and then another Acting." So I said sure, 90 days, works.

Then Daschle said he wasn't coming. Now they don't really know what to do. Everyone expected the new team to come in quickly and get started. Bill Corr was the Deputy Secretary, and he basically ran everything until they could bring political appointees into the department, which took a long time. We still had acting general counsels and acting in other divisions. And then a few people would start coming to take over. At CMS, we were one of the last; we just kept getting political appointees to come in and be responsible for the programs but not as the Administrator.

So for example, Jonathan Blum came in. Jonathan Blum was a political appointee running Medicare. He reported to me as I was the Acting Administrator, but I was a career person, not a political appointee. It was an odd arrangement because it usually doesn't happen that way.

It became much more of a partnership between the agency and the political appointees, and that was the beauty of the job for me. This really was a partnership with the career people.

At that time it wasn't so much about the political agenda. It wasn't, "Charlene, you're going to talk to Senator so and so," or "We're going to have a dinner with him." I didn't do that part. What I did do is listen to how they wanted the ACA to be implemented and what they wanted in the legislation for their agenda to work. My job was to help them understand if you want this to happen these are the things you need in legislation to make sure the agency can make it work, so that it's not vague. We wanted to not be fighting for the next 30 years about what was intended. So we had the privilege of being able to be a part of those discussions in real time with the goal of making ACA something that when it was passed we didn't have to spend a lot of time figuring out what it was. We were really a part of that discussion.

Berkowitz:

The logical follow up question to that relates to implementation. This was legislation in which people really thought about implementation rather just about passage. However, the implementation still had lots of problems.

Frizzera:

Yes, the implementation had some operational problems. But many of the issues were things it would be hard to predict in writing legislation. I'll give you a Part D example and then I'll compare that to the exchange from the ACA.

In Part D, one of the provisions allows Social Security to withhold the Part D premium from Social Security beneficiaries' checks. The career staff said "Wow, that's a little risky. We don't really share that kind of information with Social Security so that's kind of scary for us." The two systems (CMS and SSA) were separate systems that did not integrate easily. However, the decision was made to allow beneficiaries the option. It was rolling along nothing seemed to be a problem until we got a call from a Senator. There was a beneficiary in his jurisdiction who had called and said she got a check for two cents because they took out two or three months or her Part D premium out of her current monthly check

The person had been told, "We're sorry, we forgot to withhold your premium so we're taking it out of this paycheck." The person called their member of Congress and of course they called us. The Congressional staffer said, "Well, how can you do that?"

When we investigated it, we found there were about 2,300 people with the problem. That's horrible for them, but it was 2,300 out of four million people. The issue became very public. It was in the press every time you turned around: "Part D's failed. Beneficiaries can't buy food." We dealt with it, but the public perception was very hard to address. Perception was the reality for most people. The headlines would lead you to believe the world was falling apart. It really wasn't. We designed a system that we thought worked. We didn't know what didn't work until somebody told us. You can only test the system so much.

I equate that to the same issues in the ACA. The difference is ACA was so much more visible and so much of a battleground for the politicians that anything that would happen would be a problem. And the exchange was much bigger. I'm not minimizing Part D issues; Part D was big at the time, but the exchange was so much bigger.

Having been at CMS, when I look back at what happened with the ACA, I don't think the people at CMS were that surprised that it wasn't working perfectly. They knew there were going to be things that didn't work. They knew there would be glitches. I think what they didn't know was how to fix it. So with Part D, the issues were with our systems and we knew how to fix things. I think the ACA exchange was so new, the whole process was new, that they really didn't know how to fix the problems. So what happened? They brought somebody in and they fixed it.

The ACA didn't work perfectly at the roll out, but I'm in the camp that says, "But they fixed it and it's working now." When you think about it, think about all the things that did work. Thinking so much about what didn't work is kind of a shame because most of the stuff really did work well and has an impact on millions of Americans.

Berkowitz:

I see. It reminds me a little bit about the implementation of SSI (Supplemental Security Income), which also had some problems.

Frizzera:

Exactly. The ACA had bigger issues, bigger visibility, a bigger impact, but it was the same in terms of needing to fix some things.

Berkowitz:

Although we would like to say that over time we get better at this.

Frizzera:

Well, here's what I would say. I say we do get better, but things get bigger. Look at the ACA. Look at all that did work. I think the changes get bigger, but we do get better.

Berkowitz:

I'll move on to some questions about your work. When you were Acting Administrator did you ever have a moment where you said, "I'm the Acting but it would be much more helpful if I was actually the Administrator"?

Frizzera:

Never -- for a couple of reasons: One, they had a lot of politicians doing the politics for ACA. Honestly, they didn't need another politician appointee, at that time, to address the politics of ACA. The White House was very involved, more than a White House is usually involved. The ACA was gigantic, and they had lots of very powerful people doing that. Never did I think, "Wow, if I could just be a part of that, my job would be better." I actually thought my job was different than a political appointee and in some ways more challenging because I wasn't the political person.

My job really was being close enough to the political appointees to know what they wanted and to be the face of the agency to make it happen. And I couldn't say, like a political appointee could, "Hey, this is our agenda, this is what we believe." I couldn't do that. That was not my job. So my message had to be about the organization of CMS running the programs, not about the politics of legislation being passed.

Berkowitz:

So could you say, "Mr. Congressman, you made the law. We're just putting it into effect."

Frizzera:

Correct. My job when they would call me and when I would talk to the Hill would be about explaining how this impacted CMS, how it impacted beneficiaries, based on what CMS knew and did.

Berkowitz:

Your career was inside the bureaucracy through Democratic and Republican administrations. Could you tell the difference?

Frizzera:

Definitely. I would say the most obvious had to do with fiscal matters. I don't want to use a word that says one's better than another, but generally the Democrats were much more generous in spending, in program spending, in administrative spending. Republicans were definitely more conservative around program spending and more conservative with the administrative budget and spending.

I don't mean that the Democrats' spending was necessarily reckless spending but just more generous, understanding that in order for their social programs to work, they did

need money. Social programs cost a lot of money. Republicans weren't so crazy about the social programs, so they made very different decisions on spending.

With the Democrats, in this administration for sure, there are many more federal regulations in the Medicaid program. The ACA included a lot of federal requirements for the Medicaid program. Republicans have the philosophy, "States need to figure out how to run these programs. We have some minimum Federal requirements, but the States know better how to deliver and pay for health care in their state."

That philosophical difference was a very big difference between the two parties. I think it's more evident in the Medicaid program because the parties are such at odds on how much the government should intervene in state business. But even in the world of the Medicare beneficiary, the Democrats are much more willing to regulate more for Medicare beneficiaries. The Republicans are willing to let beneficiaries make more decisions and have more choice than they have now.

Berkowitz:

I see. Could you tell me a little bit about what you've been doing since you left CMS?

Frizzera:

Yes; this has been really a fascinating four-and-a-half years. I formed a consulting company. I have a public program background. My partner came out of the business side of healthcare. He has a Masters from Columbia; he did a lot of healthcare investment work in New York. He worked for a hedge fund for a while so he really understood how the business world looks at the healthcare delivery system and what's important to them.

When I left CMS he decided he was going to leave the hedge fund. I said, "Why don't we just see if people want to talk to us?" And four-and-a-half years later, the integration of that discussion of how business looks at healthcare and how the government looks at healthcare has been incredibly eye opening. We spend most of our time trying to bridge that gap.

For businesses in the healthcare delivery system, we talk about what the government cares about. The government doesn't care how much money you make or if you go out of business except as that impacts beneficiaries. Government cares about the impact on a beneficiary of what you're doing. If you going out of business means there's a negative impact on a beneficiary, the government cares. If you're going to go out of business and there are other people who can provide the same care, government doesn't care.

I have seen that everyone cares about the beneficiaries. The differences are the way we talk about it and the way we think about what we're doing.

It has been great to be able to help businesses understand that at CMS, it is all about ensuring beneficiaries get the right care at the right price. That's sincere; that's just not a line. People get up every day and are very proud of what they do to protect the people that we serve.

It's also been an incredible education for me. When I was at CMS, we spent most of our time administering the program through regulations. You don't always have the time to analyze the changes made in the health care system. I know understand that the industry and CMS could work together in a partnership to share more openly the intent of the delivery system changes and the impact, positively or negatively, on beneficiaries.

I've been pleased to be able to provide some of that education and help bridge that gap between government and industry. They have to come together for healthcare to really be changed. The ACA will work when that happens.

Berkowitz:

Interesting. So, last question: do you have any predictions or insights about the future of Medicare and Medicaid?

Frizzera:

Yes. I think the future of Medicare and Medicaid is definitely going from volume to value. The healthcare delivery system is going to migrate to health outcome improvement.

I think for health outcomes to improve, providers have to behave differently and beneficiaries have to behave differently. So we have to figure out how we get providers to deliver care differently in order to get a better health outcome in the long run, not just treat the immediate need. And more importantly, how do we get beneficiaries to behave differently? How do you get beneficiaries to stop smoking? How do you get them to really deal with their diabetes?

I think one part of the answer lies in the care coordination model where somebody takes care of that patient for the whole spectrum and they deal with issues other than the medical need. You get to deal with behavioral health. You get to deal with social needs. Combining all that into a healthcare delivery system is really important to making the future of the healthcare delivery system improve health outcomes for people. I honestly believe the ACA provides a lot of opportunity for that pathway. I tell people all the time when I talk to them, "If you aren't talking to a non-traditional partner, you should talk to them, because if you're not doing something different or thinking about how you're going to do your business differently moving forward, you're not going to survive in the end."

Berkowitz:

I see. So if that's going to be the future then the Democrats and the Republicans can fight about how much the government's going to do that and how much the private sector's going to do.

Frizzera:

Exactly. That's the big battle.

Berkowitz:

Right. Thank you so much for doing this interview.

Frizzera:

You're most welcome.

Interview with C. McClain (Mac) Haddow

Washington, DC on June 8, 2015

Interviewed by Edward Berkowitz

Transcript edited for clarity.

Berkowitz:

Today is June 8th, 2015 and we are at the National Academy of Social Insurance headquarters in Washington, and I'm talking to C. McClain Haddow. By what name do you like to be called?

Haddow:

Mac.

Berkowitz:

I'd like to ask you questions about your background a bit, biographical details, and then I want to ask you some questions about your work at HHS and CMS in particular. So if I read your biography correctly, it says you were born in Pittsburgh. Is that right?

Haddow:

That's correct.

Berkowitz:

So how did it happen that you were born in Pittsburgh and then you moved to Utah after that?

Haddow:

Both of my parents were born near Pittsburgh, and after they were married our family lived in various locations near downtown. When I was nearly 4, my father died of cancer and my mother was left penniless to raise five small children. Several years later, my mother remarried to a man who turned out to be an alcoholic who showed no interest in any of the children in our family. We lived in a tough neighborhood, and when I was about 10 years old some Mormon missionaries knocked on our door and proceeded to teach my mother a series of lessons about the Mormon church. These missionaries were very persistent, and after an extended period of their repeated visits, she agreed to allow her four boys to be baptized if the missionaries would agree to leave her alone. The deal was struck, but after we were baptized my mother observed an amazing experience that she had not seen before in the form of people from the church coming to our door and offering rides to various youth activities and to church on Sundays. It was shortly after that that my mother also was converted to the Mormon church.

As we grew up in the church, we became very familiar with Jess and Helen Hatch, who were the parents of Orrin Hatch, who later became the United States Senator from Utah. Jess and Helen Hatch were like a second mother and father to me. They had migrated to Pittsburgh during the Great Depression in search of work. Orrin's father, Jess, was a

Wood, Wire, and Metal Lathers Union man who, when he found a job, settled in Pittsburgh, and they lived their lives there as their children were growing up. When the Hatch's retired and decided to move back to Utah, I drove the U-Haul truck with their furnishings.

When I graduated from high school, my mother was interested in making sure that I got on a good path, and so she encouraged me to apply to Brigham Young University (BYU) in Provo, Utah. BYU is a private church school run by the Mormon church. I had already applied to and been accepted at West Virginia University (WVU), which my mother thought was too much of a party school and the wrong path for me, so she encouraged me to apply -- very late in the game and well past the admission deadlines -- to BYU.

I finally yielded and said, "I will submit an application for admission and if they do accept me I'll go." And that's what happened. At the time, I was disappointed because I had looked forward to attending WVU. I thought it was very surprising that after missing all these deadlines they would even accept me. But I had done well on my ACT scores which is what they used as part of the admission criteria. That, and just putting your tuition check on the table got you into BYU at the time. It is much stricter today. My children have all gone -- most of them have gone there and I found that they're smarter than I am and were accepted under much more rigorous standards.

That's how I ended up at BYU and while there, in my senior year, Orrin Hatch decided to run for the United States Senate. I called and asked Orrin what I could do to help and ended up being involved in and actually becoming his campaign manager for the U.S. Senate in 1976. And so that was how I both ended up in Utah and in politics. I had never really done anything in politics prior to that, but Senator Hatch had a very successful first campaign. He was elected beating a very entrenched incumbent, Frank Moss, who the *U.S. News and World Report* had called the safest seat in the Senate that year. But Orrin Hatch had separated himself from the Republican field by running as a very strong Reagan conservative who believed in smaller government and lower taxes. It resonated with voters.

Berkowitz:

An unusual election too. There a lot of people that you wouldn't expect to have wanted to run in 1976 right after the Watergate disruption in politics.

Haddow:

It was an unusual election, and later there was a more dramatic shift for the Republicans, of course, in 1980 when Reagan came into office and his coattails allowed the Republicans to take control of the Senate. But you're right. In 1976 it was a very interesting philosophical shift in the population as they started to move in a direction that really cascaded in the '80 elections.

Berkowitz:

When you went to Brigham Young, you were not yet living in Utah or you were living in Utah?

Haddow:

I was not. I came from Pittsburgh and migrated to Utah just to go to school.

Berkowitz:

Orin Hatch was first elected to Senate in 1976 and as far as I know he's still here in Washington?

Haddow:

He is.

Berkowitz:

So he's really an elder statesman at this point. But I'm surprised from what you've said, that he doesn't have a Utah background. Is that right?

Haddow:

This is an interesting situation. The Hatch family was one of the Mormon pioneers in Utah. His father was a descendent of the polygamous clan of Jeremiah Hatch whose family had settled in the eastern part of Utah -- in the Vernal area. The Hatch's were a very large and influential family in the area. In fact, my wife is a descendant the third wife of Jeremiah Hatch in the polygamous world that they lived in at that time. And Jess Hatch, Orrin's father, was a grandson of the first wife of Jeremiah Hatch. So we were distantly related through that polygamous connection.

That is a connection that I knew nothing about until I had met my future wife and, as we were preparing our wedding invitations, I learned her father -- whom I'd always called "Bud" -- was actually named "Jess Hatch Davis." So we found that interesting family connection which wasn't obvious to me when we were first dating.

Senator Hatch had a very strong base of support in Utah just because of the Hatch clan that had been there for a few generations from the Mormon pioneers immigrating there. During the election, Senator Moss repeatedly made a big point about Orrin being a so called "carpet bagger" from Pittsburgh and did not really have any Utah roots. In the Chamber of Commerce debate that is now infamous in that election, candidate Hatch stood up and warned Senator Moss that if he didn't quit denigrating the Hatch name, the Hatch family would rise up and throw him out of office all on their own [laughs].

Berkowitz:

And just so I'm clear, Frank Moss was a Democrat?

Haddow:

He was a Democrat.

Berkowitz:

So that was the seat that the Republicans took in 1976?

Haddow:

They did. Senator Moss was entrenched; he had done well in Utah during his 18 year career despite being a Democrat in a very conservative state.

Moss was, at the time, not an active LDS (Latter-Day Saints) member, which was unusual for a successful elected official in Utah. He had served in the Senate for three terms, and he had a very strong base of support in Utah, but his voting record on key issues of importance to Utah voters really didn't sync up with the political views for the Utah population. A lot of his success in elections was because his office was very good at constituent service. He paid attention to the folks back home. When we ran the campaign against him, we focused on the disparity between the positions that he took as a leading Democrat here in Washington, D.C., versus the mainstream views of the conservative LDS Republican voter base in Utah. And that's where we found significant inroads that ultimately led to a huge upset.

Berkowitz:

So you say that Senator Hatch was a sort of change in direction for the Republican Party in Utah. Is that right?

Haddow:

At the time that Senator Hatch ran, there was an interesting dynamic that occurred in that there were five Republican candidates running against Frank Moss who was, as I mentioned earlier, being called the safest seat in the U.S. Senate according to the *U.S. News and World Report*. So why did he lose that election? Well, there were a couple of reasons.

Jake Garn, then the sitting junior Senator from Utah, had recruited a candidate named Jack Carlson to run against Moss. The thinking was that Carlson would lose to Moss, but he would establish a strong name identification with voters and then be the heir apparent when Moss completed his fourth term in office.

Orrin Hatch, who had only moved to Utah from Pittsburgh about six years earlier, really hadn't been involved in the Republican Party in Utah prior to that election.

The other candidates in that field other than Orrin Hatch were Jack Carlson, who resigned his post as assistant secretary in the Ford Administration; Sherm Lloyd, a former Utah congressman; Des Barker, who had worked in the Nixon Administration; and Clinton Miller, a former lobbyist.

Orrin Hatch distinguished himself in the campaign as being a Reagan Republican even though Ronald Reagan lost to Gerald Ford at the Republican National Convention that year. But Hatch set himself apart right from the get go as a Reagan Republican while Jack Carlson, who was an ally of Jake Garn, appealed to the more moderate Republicans and supporters of President Ford. So that was what divided the Party, and in that year the conservative base in Utah was strongly pro-Reagan, and Hatch unabashedly was a pro-Reagan conservative and made no bones about how he favored Reagan and his policies over Gerald Ford. That aggressive style of campaigning helped Hatch rise to the top tier of candidates.

They have a unique election structure in Utah where it's a convention system. At the time, if a candidate got 60 percent of the vote of delegates elected to a convention, then he or she was the nominee for the Party; anything less than that, there would be a primary

between the top two vote getters at the convention. So the goal of our campaign was to get Orrin Hatch in a position where he would be in the top two and keep Carlson from getting more than 60% of the vote so that we would have a primary. Jake Garn's folks just felt like there was no chance that anyone was going to overwhelm his political machine that he had built. And Garn was backing, of course, Jack Carlson.

Berkowitz:

And he was a senator?

Haddow:

Jake Garn was a senator, yes. He was the sitting junior senator then. The voting at the convention ended up being very close, with Carlson getting about 32% of the vote and Hatch came in with 30%. That locked up a primary election.

Berkowitz:

So in 1976, you were obviously relatively young?

Haddow:

Twenty five at the time when the campaign started.

Berkowitz:

Twenty five at the time and you were running the campaign? It sounds like a very large responsibility for a 25 year old.

Haddow:

And shocking -- it took a couple of things to happen for that event to occur. One was Orrin filed the last day possible so all of the politically experienced people that you would typically see staffing campaigns had been absorbed into the existing four candidates on the Republican side, so there was no experienced political talent available to speak of that had experience in running a political campaign in Utah.

Orrin had recruited two very young guys to help him with his campaign. One was an MBA who had very good skills in the MBA field. The other was a close friend of his who was an attorney and who had worked closely with President Reagan as an advance guy. So his thinking was to take a chance and rely on people he knew to run the campaign. I merely volunteered to help in the campaign by attending my neighborhood mass meeting and getting elected to be a delegate.

In Utah, you'll get elected as a delegate in a neighborhood mass meeting in your area -- and then if you get elected you go to the state convention. I called Orrin on the night of the delegate meetings, the mass meetings, and explained to him that they had created a new voting precinct where I lived in Orem, Utah. There had been a split between two Mormon wards in this new voting precinct, and in the other Mormon ward there were two candidates that were running to be the delegate and I was the only one from my ward. So the two candidates from the other ward split the vote among the people they knew, and I got all the votes from the people in my ward that I knew -- and I snuck through and became a state delegate.

I called Orrin and I said, "Look, I got to be a delegate." He said, "This is great news." He said, "You're the forty-fourth delegate that we got." And I said, "Oh, that's wonderful." I said, "How many delegates are there overall?" He said, "Twenty-five hundred [laughs]." I said, "Well, we've got a problem." So he said, "You need to help me in Utah County," which is where I was going to school at BYU. Orrin said, "You need to set up meetings for me with other Utah County delegates." He said, "And we'll do the majority of them in the morning before people have to be at work." And they don't call them coffee klatches in Utah, of course, but they're continental breakfast affairs. And that's the way candidates usually connect with delegates.

So I started doing that and I set up one meeting after another, and every time I called the campaign headquarters I got every date I asked for. Utah County is one of twenty-nine counties in the state and although it's the second largest county, it just seemed odd to me that I could get every date I asked for. And so I asked the campaign scheduler why. He said, "Well, no one else is doing any work to set up delegate meetings." He said, "You're the only one so far that's even trying to schedule these meetings." So, that sort of elevated my stature in the campaign only because of the inefficiency of the other people working in the campaign.

But there was a campaign consultant that was sent to Utah to evaluate Hatch's campaign from the Republican Senatorial Campaign Committee and the RNC. Paul Newman was his name, like the actor.

I picked Newman up at the airport and on the way to meet Hatch he asked me to provide an evaluation of the campaign. I really didn't have any experience with the campaign other than the limited dysfunctional delegate meeting scheduling. I offered some observations about other parts of the campaign that seemed to be functioning poorly, but I explained I really didn't have any real data on any of the campaign operations. At the end of the day, I was asked to pick Newman up to take him back to the airport. He said, "Everything you told me about the campaign was true, only it's much worse for Hatch. He's going to lose badly. And I've told him unless he cleans house, changes direction and gets a new campaign manager and really starts doing what he should do in this campaign he's going to lose badly and lose his ability for future elections to come back into the political system, so I've told him that you should be the campaign manager." I was just a 25 year old kid in college. I said, "You're crazy." He said, "No." He said it's because of how bad that campaign is.

Newman said, "So Hatch is going to call you and ask you to drive him to Logan, Utah to a campaign event tomorrow and he's going to pitch you on being the campaign manager." He said, "You tell him no unless he gives you carte blanche authority to fire everybody that's currently in his campaign operation and start over." He said, "If he does that, you call me and I'll give you a blueprint of how you can make this campaign respectable."

So the next day I got the call. I drove Orrin up to Logan, Utah, which is about a two-and-a-half hour drive, and he beat hard on me to be the campaign manager -- but just for the purposes of satisfying the Republican National Committee consultants so he would have a chance to receive some funding from them. I told him I couldn't do that. I had to have the authority to actually run the campaign or it was not going to work.

We talked during the entire ride back home, and an additional discussion in front of his house into the wee hours of the morning, and he finally agreed. The next morning we had a campaign staff meeting and Orrin stood up and announced to the dozen or so staffers that I was going to be the new campaign manager. It was a shock to everyone on the campaign team, and as you can imagine they were not prepared for that announcement. But Orrin just said: "I'm going to make Mac the campaign manager and he's going to brief you in what we're doing," and he walked out.

I sat there with these twelve people, all of whom objected and claimed how ridiculous the decision was and questioned whether Hatch should do it. I stood firm and said, "Well, I'm sorry, but we are doing it. And if you're on board fine, but I want to evaluate all of you." And at that point they all just sort of did a mass exit saying, "We're resigning."

I said, "Great. See you later."

Then we actually built a campaign literally from people that I knew in college, and I started recruiting fellow college kids to join the campaign. Frank Moss's campaign called us the "basinet corps" because we were just a bunch of young kids who didn't know anything about politics. But we followed the direction that Paul Newman gave us and stayed as disciplined on the campaign plan as we could. The one thing that helped in that campaign was that we didn't have the experience and were not restrained in our thinking by that. If we had done a traditional campaign, I think Orrin would have lost.

People ask me all the time, "What was the pivotal moment in that campaign that made the difference?" Other than the endorsement of Governor Reagan for Orrin that was the catalyst for beating Jack Carlson in the primary election, Orrin proposed to send a recorded message from him to every delegate. Remember, this is 1976 and there was not Internet, email, FaceBook or other technology to communicate with voters other than paid media and direct mail. Orrin had used his legal expertise to develop a program to advise doctors on best practices to avoid malpractice suits. This program was a series of recorded cassette tapes that were sold to doctors.

Berkowitz:

That was at the cutting edge of technology.

Haddow:

Yes, at the time it was the cutting edge. Orrin had developed this series of cassette tapes that he was selling to doctors, and it was a venture that was very successful. He said, "I'm going to cut a cassette tape to the delegates."

Orrin cut the tape and produced the 2,500 cassette tapes, and then showed up at the campaign headquarters carrying two shopping bags full of these cassettes to send to all of the delegates, which we did. When we tested it later, we found the 12-minute cassette tapes mailing was the most significant campaign event that set Hatch apart in the delegates' minds, because they'd never seen anything like this, to get a cassette tape that they could play and have a personal connection with a candidate. It really pivoted him into a leader among the delegate population.

The convention was in June, and the primary in the first week in September, and we kept tracking voters as best we could. We didn't have money for polling, but we did some in-house polls that confirmed what the Carlson campaign was saying that Hatch was running a distant second. But, on the Friday before the Tuesday primary election, we had finally secured a connection with Ronald Reagan's office and political staff. Reagan had lost the convention. We asked them if we could get Reagan's endorsement since Hatch had been such a strong supporter of the Governor. We hung our hat on one of the statements that Reagan made when he had lost to Ford in the convention where Reagan said he was going to continue to fight for Republican candidates that shared his values and ideals about limited government.

So we pitched Reagan's staff hard. We said "there's a clear difference. You've got Carlson who's for Ford and you've got Hatch who has been for Reagan from day one." Stunningly, they consulted with Governor Reagan and he gave Hatch his endorsement.

It was really an interesting thing because it happened on a Friday morning, and Hatch was out shaking hands at some building as people were coming to and from work, and I went and caught up with him so we could make an announcement. Orrin said, "I can't just say I have the endorsement. You've got to have some documentation." So I called Mike Deaver, who was the person I was working with on Reagan's staff, and he agreed to send a telegram." I said, "Great."

We scheduled a press conference for 4:00 p.m. that afternoon, and we waited all afternoon for that telegram. But it didn't arrive until about 3:00 p.m. in the afternoon. We were elated, but there was one big problem: The telegram and the endorsement said it was for "Warren" Hatch, W-A-R-R-E-N.

So we tried hard to get back in touch with Mike Deaver, but he had left and now there was no way that we could get the telegram corrected. And so we did a very sloppy job of trying to correct it, but the press caught it right away. And even though we knew we had the endorsement from Governor Reagan, the obvious question was: "Is this a real endorsement?"

We needed a personal affirmation from Reagan that the endorsement was real, but the Governor was apparently on vacation in Mexico at a ranch and unreachable -- according to the Reagan staff. The word got out that Hatch had just faked this endorsement, and Jack Carlson was making hay of that issue. There was no way to verify it.

Reagan got word of it somehow. Somebody in his office got to him. We had already determined that we were doomed to defeat since the Governor was supposedly unreachable. But on Saturday evening, Reagan made a personal phone call to KSL radio, which was then the radio station with the largest reach in Utah. They had a political talk show on Saturday evening, and Reagan spent 45 minutes extolling the virtues of Orrin Hatch and just nailed it. That pivoted us from a sure defeat and turned the tide for the primary on the following Tuesday. Hatch beat Carlson and ended up beating Moss in the general election. A little closer margin in the general election, but it was still a great race.

Berkowitz:

So you then, as I understand it, actually went to work for Senator Hatch after the election of 1976. Do you work in Utah or Washington?

Haddow:

I came to Washington and worked with him here, and stayed about a year until we did our first poll. Polls in those days weren't as ubiquitous as they are today. They're expensive, and we didn't have a lot of money after the campaign. We had a big debt we had to pay off.

When we got to that ninth month of Orrin being in office, we did a poll that found that women didn't just dislike Orrin; they really hated him. The gender gap between the views of men and women on Hatch showed Orrin had a 58 percent approval rating among men, but it was an abysmal 21 percent among women. It was astounding.

Obviously Orrin would lose in the subsequent election five years hence unless the gender gap was fixed. So we put our heads together and said, "Mac, you've got to go back to Utah and build the best constituent service operation possible." I worked for him in Utah for about a year, but we were making only marginal improvements and we realized it really was going to take a strong political effort to show women voters they could trust and believe in Hatch.

I left my position in the Senate office and started a political consulting firm. I also worked with the Reagan campaign on gearing up for the 1980 campaign. We drilled down hard to determine what the problem women had with Sen. Hatch, and we found that most women perceived him as being "too arrogant" and too much like a "slick lawyer in pinstripe suits." In fact, some of the polling data show that a significant number of women in Utah believe that Hatch probably slept in pinstripe pajamas. They just thought he was too uptight.

As we talked to experienced advertising people about the problem, we all thought it was a bit odd given that Hatch was both articulate and perceived by most women as very handsome. We thought those would be political pluses. But it was just the opposite. Women held those virtues against him. So we developed a strategy where Hatch would dress down a little and work on becoming more approachable. We worked hard on developing an advertising strategy that showed Orrin to be the quality of person that women expected of their senator.

It took a little time, but finally we were able to turn the tide and the gender gap started to narrow. One of the most important things we did was an idea that Orrin had himself to start a women's conference in Utah. The Equal Rights Amendment had generated a lot of attention nationally, and there was a cultural issue in Utah where the dominant Mormon religion was perceived to give power to men in the priesthood of the Mormon church, while women were left with little or no power. Orrin's theory was that women simply did not feel as empowered as men politically, so we started the women's conference and ended up attracting thousands of women to this conference year after year that featured seminars that are all about women's empowerment as homemakers, as professionals in the workplace, in community service, and in the political realm.

In the end, I believe that the women's conferences were the catalyst for a complete reversal of the perception that women had about Orrin Hatch. The gender gap virtually disappeared.

At the same time, I ran and won election to the Utah Legislature.

Berkowitz:

You ran for election in 1979, was it?

Haddow:

That's correct.

Berkowitz:

And you ran for the state legislature, the lower house of the Utah State Legislature. So how did that all work out -- you're working for Orrin, you're running for office, and also participating in the incipient Ronald Reagan campaign that's going to be successful in 1980?

Haddow:

I left Hatch's staff and was just doing political consulting. One of my tasks was to sit on a nominating committee for that particular district in Sandy, Utah where I lived to help find a candidate for the Utah House, and we couldn't find a candidate. So the committee members pitched me to go down and sign up and they promised me I'd be a placeholder until they could find someone that would fill that slot. We had to meet the filing deadline, and so I did that and we never found another candidate, so I ended up running and getting elected to the Utah Legislature in the House of Representatives from the 25th District.

I was then working on the Reagan campaign helping in the western states. I got very close to Lyn Nofziger and the campaign operation there; Frank Keating was also helping us in that area. I learned a lot about the political process, but it was demanding in terms of time -- serving in Legislature, working on the Reagan campaign, and also trying to make a living.

When Reagan won, Lyn Nofziger pushed me hard to come back and be a part of the Reagan Administration in Washington. I resisted that. They then offered me a slot in Denver in the Regional Administrator's Office at the Department of Housing and Urban Development, and so I accepted that. But the White House Personnel Office didn't clear my appointment with Jake Garn who was then on the Housing Committee in the Senate, and Jake Garn still felt a little bruised in the intervening time with Hatch defeating his designated candidate, and the truth was he and Hatch were struggling a little bit with their relationship. That resolved itself over time, and now they are great friends -- but at the time there was tension. So when Senator Garn found out that I had been appointed to go over there to the Regional Administrator's Office, he objected, and so there was a little bit of tension and turbulence. I ended up working there in Denver for only about six months, but clearly tension with Garn had limited my ability to take the Regional Administrator's slot which was the plan my contacts at the White House had promised.

As an alternative, I was asked to come back and interview with Terrence Bell, who was then the Secretary of Education, to be his Chief of Staff. I knew Secretary Bell very well. He was from Utah. We had a good relationship, and so I sat down with him and he said, "Mac, this is great. But this is something that the White House doesn't know -- I'm leaving the Department." He said, "So there's no point in you coming back here and becoming Chief of Staff of this Department because I'm going to be gone from here in the next four to six months."

Secretary Bell bound me to secrecy. I couldn't go back and tell the White House personnel office, because Bell didn't want to disclose his decision yet. So I had to tell Lyn Nofziger I was still thinking about this, and it didn't seem like a good fit because of the Utah connection, and asked that we look at something else. So they set up an appointment to interview with the top staff at HHS; the Secretary was then Margaret Heckler. I went over there -- went through that interview. They told me that I would probably hear back from Secretary Heckler to see if she were interested because I had passed the first interview process over at HHS.

I didn't hear anything for several weeks, so I thought it was a dead end. I was working at HUD in the Washington office and I got a phone call from a woman who purported to be Margaret Heckler. She said, "I would like you to come see me right now and meet me at this elevator because I want you to ride in the car with me to an appointment." I thought this was a couple of my friends setting me up on some joke, and so I kept saying, "I'm sure this isn't Secretary Heckler calling me directly and telling me to meet her in an elevator." She goes, "No, it really is." I kept resisting, but the more we talked, it became clear it was Secretary Heckler on the phone.

Berkowitz:

Her Boston accent gave it away?

Haddow:

[laughs] Exactly, yes. So I met her at in the parking garage near the elevator at the HHS building and got into her limo with her, and we had a nice chat for about a half hour as she was driving to an appointment. She offered me the job to come and work as her Executive Assistant.

She had a fellow who was in the Chief of Staff position that she had brought with her from Massachusetts; she was very comfortable with him. So I worked as the political guy. The White House, as they described it to me, wanted someone that they could rely on that was a good conservative, because the Department was being run by a guy that had no political experience but was very close to Secretary Heckler and he was resisting their efforts to try to rein in some of the policies that Secretary Heckler was inclined to support which were not consistent with the Reagan agenda. So I was supposed to be the plant to go over there and, to the extent I could, guide her to a more conservative position. She understood this, by the way. She knew there was some consternation at the White House, and she wanted to have someone that had good connections with the White House team. So my connection with Lyn Nofziger, which is what she predicated her decision on, was a very positive thing for me.

It was interesting because about four months later she had run into Senator Hatch at an event and Senator Hatch said, "Well, I understand you have my former campaign manager, my good friend Mac Haddow working for you?" And she came back from that meeting and immediately called me into the office and she said, "Are you a Mormon?" I said, "Yes, Ma'am." And she said, "If I'd known that I never would have hired you." I said, "Really, why's that?" She said, "Because I've had Mormons work in my congressional office. They're too family-oriented. They want to go home at night and take care of their kids, and they don't want to work like I need them to work. I had terrible experience with Mormons because of that split between working and family." We had a good laugh about it, because I had five children at the time. I said, "I have a big family too." And she said, "Well, you haven't shown that you're ready to run out." I said, "Well, I try to strike a balance, but my job here is what it is."

It was an interesting exchange between the two of us because she really had not understood the background connection I had politically. She had just focused on the relationship that I had with the White House personnel people.

Berkowitz:

She is from the Massachusetts Congressional Delegation. I think she had a suburban Boston District, like in Wellesley, and to be in that district in that state you have to be pretty liberal to blend into the prevailing political culture. So she was quite different from you?

Haddow:

Very different politically, but she had lost her seat because she supported the first Reagan budget.

Her own personal desire was that the President would offer the Attorney General's slot to her. But that showed her lack of understanding about how this was going to work. The philosophical underpinnings of Reagan administration were not things she supported. She supported him on the budget, and they offered her a reward for her having lost her seat, but she didn't have a good connection with the realities of politics to think she would be asked to be the Attorney General.

So the HHS position was one that they thought they could offer her because the Reagan administration already viewed HHS as an uncontrollable bureaucracy and most of the entitlements were governed more by what Congress was doing than what the administration could take on. They changed that view later, but that was their initial view. So Heckler got that position and she always chafed a little bit because she would have much preferred to have been over at the Justice Department as the Attorney General.

Berkowitz:

As her Executive Assistant, did that job get into policy substance or is that mostly making the trains run on time and managing the office and that sort of thing?

Haddow:

Well, the management of the office we left to the Chief of Staff, and I became the policy guy that was trying to make sure that we were guided by the Reagan philosophy. There were significant conflicts within the upper office staff because everyone viewed me for

what I was. I was sort of the hit man from the White House that was trying to get her back on track, and most of the people that she had surrounded herself with in the upper political appointee team were all Massachusetts Republicans who were very similar in the philosophy that she had.

So there was tension, but I won her confidence and respect and we had some great wins with some of the things that the President recognized her for as we started to make some of the changes. One was the development of the DRG system, which we viewed was a transition step to a capitated payment system. It was supposed to be a short transition step. We are here now many decades later, and we still have the DRG system.

It never happened, but everybody believed that DRGs were going to be just a way, a bridge, to get to a purely capitated healthcare delivery system that controlled cost. That's what we were trying to accomplish. It was a major achievement to get that negotiated in a way that was acceptable to the Congress. Margaret Heckler had the opportunity to be in the forefront of that major change in policy about healthcare reimbursement.

Berkowitz:

But which didn't get passed until 1983.

Haddow:

Right, but the development of it was a fascinating process for me. As we sat there in the department and struggled internally against a career staff that was vehemently opposed to it because their own philosophical leanings were to keep the system that we had and they didn't like these changes.

In addition, we made fairly significant changes in the way HMO's (Health Maintenance Organizations) were going to be a part of the healthcare delivery system. When we pilot tested it, it was a major battle internally within the Department as to whether or not that would ever work and ever be acceptable.

Berkowitz:

It's very interesting because the DRG's today are part of the liberal agenda as well as the conservative.

In the early Reagan years, there was a man at OMB named Carlson. He was the big welfare reform guy who had been brought from California. He was there sitting in the Executive Office building, another part of the bureaucracy. Were you working with those folks, as well?

Haddow:

Yes. What happened, and history has shown it probably wasn't the best decision in the world, but what happened was we started in '81 moving towards a budget-driven healthcare delivery system as opposed to a needs-driven healthcare delivery system. That was part of that tension in the Department. The career staff, I think as I look back on it now, were correct in saying that if we start looking at healthcare and making the primary focus how much it costs versus the healthcare needs of the patients we're trying to serve, it is a problem. That was a bad pivot, but we did it and OMB became the driver of

healthcare policy rather than letting HHS become the protector of the healthcare needs of the average beneficiary of government healthcare programs.

Berkowitz:

Interesting. Health sounds like it is becoming a bit more of an item on your radar. It's something that you got interested in? Is that correct?

Haddow:

As a function of being in that Department I became immersed in it. It wasn't something I chose other than where I landed as a part of the negotiations with White House personnel where they wanted to place people that they could trust in the administration. HHS presented the unique challenge for them given that Margaret Heckler had her own philosophical vision, meaning that they were out of step with most of the Reagan agenda. That made it a challenge for them, so I became immersed in healthcare in that way.

Berkowitz:

There's the Public Health Service, the Social Security Administration and so on. And the Secretary's office has always had to cut against that in many ways. There is generally some tension with the career people at SSA or the career people in CMS, or HCFA. Was that true in your day?

Haddow:

Not so much at SSA because it's such a huge bureaucracy. There's not much anybody can do to guide that system other than establishing what the assumptions were for how much Social Security was going to cost going down the road. And the actuary staff were pretty cooperative. In fact, they had a fellow whose name is Guy King. We used to call him "Sky King." He was their economist who would give us all the assumptions and develop them. He was willing and able to modify those assumptions in a way to deliver pretty much the estimates that we wanted. Hence, the name "Sky King." He could fly above all of this, and we used to joke about SSA. They didn't create many problems for us like CMS, then called HCFA, did. At HCFA, the career staff had a very strong view about where the agency ought to be going, and about where healthcare policy needed to be. NIH was less of a problem until the AIDS (acquired immune deficiency syndrome) problem arose. Then we got into significant conflict between the Reagan administration policy and NIH's view of budgeting for research.

FDA was a huge problem. It was probably the most difficult agency to try to corral because they were emerging as a more powerful part of the U.S. economy. Their decisions on approving or not approving drugs had a significant impact on HCFA's budgeting for reimbursement for health care providers. The FDA was probably the most dysfunctional of the agencies that I had to deal with, as opposed to the others where I could understand the philosophical leanings of the career staff. At FDA they made themselves bullet-proof because they added not only a political philosophical vision, but also scientific background. I couldn't pretend to compete on scientific background, and they would hide most of their decisions behind the cloak of scientific analysis.

I found pretty quickly that much of "scientific analysis" was a lot a malarkey, but they were skilled at it and so anytime they wanted to bully their way through on a policy decision they

would invoke science saying, “This is science and you don’t know what you’re talking about.” And they were good at it.

Frank Young was the FDA Commissioner early on at the time, and he was very helpful in working to find a good policy position on key issues. But even he was blinded, I think, to the power of the career staff of the FDA.

Berkowitz:

Well, HCFA too deals with some pretty obscure stuff. They also have command of statistics but you’re able to penetrate that more easily than the chemistry of the drugs at FDA?

Haddow:

Right, because HCFA was more susceptible to a philosophical direction that would guide policy. The biggest conflict at HCFA was OMB taking over making healthcare policy decisions driven by budgetary limits.

The OMB people put strict limits on what we are allowed to spend on these programs and so that’s why I say we made that transition as difficult as it was to a budget-driven healthcare delivery system as opposed to a healthcare needs-driven delivery system. It was a big change within the bureaucracy. But when it was imposed, it knocked most of the career staff back on their heels because they hadn’t had to deal with this kind of large systemic change in the organization. They had seen piecemeal attacks before on various operations, but they hadn’t seen this kind of restraint. And literally there were approvals required from OMB on every policy change that we were proposing that was tied to a healthcare need of an individual program. So that was a huge policy shift that was interesting to watch because you would see the career staff start to find ways to stop OMB – a fascinating game of policy chess.

As one example -- when I became the Acting Administrator at HCFA -- at one of the first meetings I had the career staffers came in and said, “OMB is telling us that on these HMO’s (health maintenance organizations) that we cannot do the following things.” They presented a list of grievances about what OMB was restricting them on -- exercising regulatory restraint on HMO’s. And they had a list of all of these horrible things that they predicted were going to happen if they didn’t impose these very onerous regulations. One, for example, was the advertising limits on where the HMO’s could advertise if they were part of what became the Medicare Advantage Program. It involved a number of HMO’s that we were pilot testing trying to get integrated into the system.

The animosity by the career staff in reacting in those decisions was palpable. My view was obviously more pro-Reagan, more pro-business. I told them, “No, we are going to implement these kinds of restrictions.” The career staff literally said to me, “Yes we are.” I looked around and said, “I thought I was the Acting Administrator.” The staff was very adamant about it and resisted internally most of what we did. So we had to, in various ways, roll them. It took a while to get through that.

Berkowitz:

So what was the real issue? Was the real issue that they thought that having advertising would influence the choice unduly toward HMO's as opposed to traditional Medicare?

Haddow:

Well, the core problem started when we did the pilot programs. It involved one of the HMO programs down in Florida. It was the very controversial one -- IMC (International Medical Centers). The issue related to the requirement to meet a 50-50 split between government and commercial enrollees; you had to have at least 50 percent commercial enrollees to match the Medicare enrollment. The pilot programs were restricted to limited urban counties. The argument that IMC, and similarly situated urban based HMOs in California, made to us was you can't do that if you don't allow us to expand enrollments beyond just the arbitrary political boundary of a county. That boundary in the IMC case in Miami was Dade County. I don't recall the subsection of Los Angeles where this other one was operating, but their argument was we can't buy ads targeted just to those areas. They said "We can meet the 50-50 but only if we're allowed to advertise and enroll patients outside of the restricted county boundaries."

The HCFA career staff wanted to limit the enrollment to just the pilot counties, and they rejected the argument that advertising overlaps other county lines. The HCFA career staff also wanted to prescreen all advertisements and have the power to approve or reject advertising scripts. The HMO experience had been that HCFA was routinely taking as much as 120 days to approve a television ad. And so I got involved in the process that was being used for those approvals or rejections.

The argument that the career staff had was twofold. First, they said that Medicare enrollees will never depart from their fee-for-service doctors so the HMO scheme was going to be a huge waste of taxpayer money. They argued Medicare patients were wed to their fee-for-service doctor. They claimed to have done studies. All of the analytical data supported the notion that it was a waste of money for the government to be investing in these HMO structures because the Medicare patients would never leave the doctors they knew and trusted.

The argument on the side of the Medicare HMO program was if we offered a reasonable capitated rate that would permit them to offer an expanded benefit above and beyond the basic Medicare program, then seniors would leave their fee-for-service doctor and enroll in the HMOs. Well, that was the big conflict. We found that the price threshold, the dollar threshold, for a senior to move from their fee-for-service doctor in exchange for expanded benefits, dental or eyeglasses, was fairly small. Medicare enrollees switched to HMOs in droves. The career staff was obviously upset that their analytical data and position was wrong.

Second, the career staff argued that HMOs would become Medicare sweat shops. Medicare HMOs would just be rolling people through and patients would not be getting the quality of care offered in the fee-for-service model. Well, how do you test to make sure that they're getting quality care as opposed to just being part of a HMO mill? That was the internal conflict.

The truth is we got lost a little bit because our goal became budget driven. We were going to provide the range of Medicare services at a lower cost to the Medicare population. I bought into it and I know others at HHS at the top policy level did too. Now, when we did that there were obviously pressures that built up internally. We put the HMOs on fairly tight constraints about what we would allow them to do and what we wouldn't allow them to do. But we did work to take away the ridiculous limits on their advertising and all of that. We worked to find a reasonable way to help them to get to that 50-50 split. That was our goal.

We created a war with the career staff. They found every nit-picking way they could to disparage the HMOs and take shots at them along the way. So we had to be careful to thread the needle so that we got the desired outcomes without being harpooned by our own people internally who were trying to gut this program at its core.

We had that sort of conflict all the time. One example involved the Inspector General. He was a great guy named Dick Kusserow, who was then the IG at HHS. He was aggressive in identifying waste and fraud; he was very good at what he did. He came in and said, "I've discovered a way that we can save money for the Medicare system." It was tens of millions of dollars. His idea was to delay the monthly payment to the HMOs if the payment date on the last day of the month was on a Saturday -- we would delay it until Monday. And then, if Monday was a holiday, we'd push the payment owed out until Tuesday.

The savings in interest on the unpaid bills were huge, but they came on the backs of the HMOs that we relied upon to generate a quality health care system for Medicare enrollees. That's where we got lost because we focused on saving that money, but that meant that we were putting these private businesses on the hook to float the government money that should have been paid to them on a timely basis. We forced those HMOs to borrow against the delayed payments, and they had to pay the interest rates on the delayed funds. Worse, they were not permitted to charge the government for the interest payments. All of that made it impossible to attract new HMO providers when we were squeezing down on the reimbursement levels. They got pinched.

And so the HMOs legitimately came and complained. Dick Kusserow and I got at odds -- the two most conservative Reagan Republicans were battling it out on this issue. My view was we ought to keep these private businesses healthy, allow them to have a reliable reimbursement stream, and not impinge on them when we're already saying we are not going to reimburse for the cost of borrowing capital in order to fund operations, when we're the ones who put them in the bind.

Berkowitz:

So let me get the chronology of your career straight. I believe that you actually ran for office at the State Senate in Utah, 1982.

Haddow:

I did.

Berkowitz:

Wasn't that right in the middle of all this stuff that you've been talking about?

Haddow:

Well, I ran without thinking of the implications since I was involved in the Reagan campaign, and I lost that election because I wasn't in the state very often. It might have been because I was a bad candidate, too. I mean that could be part of the equation. Utah is an interesting place in that the Mormon Church has great influence, and the fellow I was running against was a Stake President in the Mormon Church -- which is the equivalent of a Bishop in a Catholic Diocese. And so he had a significant church influence.

Berkowitz:

So a Bishop couldn't run for office but a Stake President could?

Haddow:

That's a good point. The Mormon's have a lay ministry so they have their own lives apart from their ecclesiastical responsibilities and I didn't anticipate that very well. The combination of that miscalculation, and the fact that I was gone so much working on the Reagan campaign, which I hadn't anticipated when I first got involved in the campaign, I ended up losing that race. It was in '81 when I ran and lost.

Berkowitz:

So now, you also, at some point, your job title changed to Chief of Staff in 1984, I believe.

Haddow:

That's right.

Berkowitz:

How did that happen?

Haddow:

The fellow that was occupying the Chief of Staff job wanted to go back to Massachusetts. He was a finance guy, and he had tired of this political game and I think a combination of two things. One, he had a better opportunity financially for himself back home, and two I think he felt very disconnected from the White House policy team. Prior to my coming on board, had had very intimate relations with the White House policy team on a constant basis, and suddenly I was doing that kind of thing and I think it frustrated him a little bit. He was a super guy. We were good friends. But he just candidly said, "This is no longer as much fun as it used to be." I think that working for Margaret Heckler has a fatigue factor in it, too. She's very demanding and I think it was wearing on him and his family. He was spreading a lot of time between Massachusetts and Washington -- it just was not a good situation for his family.

Berkowitz:

So they put you on the job?

Haddow:

Well, it was an intense competition for the job. There was a highly qualified guy; John O'Shaughnessy, who was the Assistant Secretary for Management and Budget. He and I were the two top candidates. I had immense respect for John -- loved him. He just lost out

and I think it was the closer connection I had with the folks at the White House more than anything else. But somehow I was selected.

Berkowitz:

Right. But it's her choice though, right? It wasn't the White House's choice?

Haddow:

It was her choice. She had to get it cleared with the White House, but it was her choice.

Berkowitz:

So, you had to take over in December of 1984. When you are looking out over the bureaucracy at that point, now as the Chief of Staff, was Carolyn Davis still at HCFA?

Haddow:

Yes.

Berkowitz:

And then Bill Roper was going to come at some point, but --

Haddow:

Well, we didn't know that. But, yes. In fact, I became the Acting HCFA Administrator and then Henry Desmarais followed me as Acting and then Roper came after that.

Berkowitz:

So Carolyn Davis was there when you were the Chief of Staff. Did you deal with her? Have a good relationship?

Haddow:

A lot. Yes. She was great.

Berkowitz:

How did she see herself in terms of this -- career people and not career people, OMB and HHS and the Bureau itself? Did she try to assert, "We have to have a little more autonomy here at HCFA?"

Haddow:

My assessment of it is that she was more of a silk-glove kind of manager. She wasn't confrontational, but she was effective in getting the bureaucracy to move the way the Reagan Administration wanted it to. I think she tolerated some of the bureaucracy's tendencies to push back, probably more than I would have. But she was very effective in getting the job done. She understood, as a policy person, the healthcare delivery system far better than I did. I think her credibility on Capitol Hill, with being able to address concerns on both sides of the aisle, was superb. She maintained very good relationships.

Berkowitz:

She was a nurse, I believe right?

Haddow:

I think that's right.

Berkowitz:

And of course, she's a woman. I wonder if Secretary Heckler felt a special bond there, that there's somebody at the higher levels in the bureaucracy who is a woman like her.

Haddow:

I'd say, no. I think Secretary Heckler was very detached from that level of management and she rarely would meet with her assistant secretaries and when she did, it was just because she had to. There wasn't a lot of interaction. When crises developed, obviously there would have to be some sort of discussions, but her management style included viewing herself being far more a spokesperson. It evolved to that. I'm not sure how she personally looked at it. Maybe she thought she would be in more control, but the hours that she put in to the job, in terms of her personal preferences, didn't connect very well with being able to manage the bureaucracy on a daily basis.

Berkowitz:

I see now that you were put into this position in December of 1984, not October of 1984. So the election was going on simultaneously with all this. I imagine that had an effect on staffing things in the bureaucracy?

Haddow:

Of course it did. Yes.

Berkowitz:

AIDS is becoming a huge issue by that time, by the time you get to the Chief of Staff. So that was very much a part of HHS's responsibility. Were you involved in that?

Haddow:

Oh yes. Part of the problem with AIDS was that it first became a public health concern. And that's the problem with it. It was a concern, not a crisis, when it first developed. We didn't understand it very well. NIH (National Institutes of Health) people came over and we talked about it. We involved the CDC (Centers for Disease Control). Dr. Ed Brandt was the Assistant Secretary for Health at the time. And we also had Dr. Jim Mason who was the CDC Director, and the NIH Director was the fellow that took the lead on it.

We had multiple meetings on this, trying to figure out, what's the scope of it? And as it continued to grow of concern, from a political standpoint, we had the blow-up that occurred when we first developed the test for AIDS, as to who owned that test and where did the scientific work occur, how did it get done? That controversy landed in my lap when the Pasteur Institute came to my office with their attorneys and said, "Robert Gallo stole this from us." That was their contention. And of course, that triggered a whole set of meetings that involved the General Counsel's Office and all the people from NIH. Gallo came in and made the persuasive case that what the Pasteur Institute folks were saying was absolutely wrong. He made a case that was compelling, and he indicated at the time that he believed he was going to win the Nobel Prize over this.

The National Institutes of Health were taking the lead on looking at this whole AIDS epidemic. We had two problems. One was the scientific part of it, and the other was the political part of it. As it grew into a political crisis, we were concerned about how we were going to deal with it.

Then the Rock Hudson thing happened. Hudson had gone over to France, he was being treated with a drug that was not approved by the FDA in the United States. The patient community demanded to know why the FDA had not approved the AIDS drug that the French were using? The FDA's position was that no application had even been filed for this drug, and there was no clinical trial to demonstrate safety or efficacy and even if we just forget about the safety part of it, there is no efficacy that they've demonstrated. The FDA believed, based on the data that they had been provided informally, that the drug didn't work. And so that became a huge hot-potato because Rock Hudson was a highly visible actor and the White House had a big interest.

It took us a while to sort through that. The fallback position we took was that until they applied for the approval, there was nothing we could do. But the truth was, the FDA said, "It doesn't work anyway." And as it turned out, they were right.

Berkowitz:

Did you ever meet with the President on this, or no?

Haddow:

I was in meetings where it was discussed, where he was present, but not when I was making a presentation. Secretary Heckler discussed it with him and talked strategy.

Berkowitz:

So you were the Chief of Staff and the Acting Administrator of HCFA at the same time, which on the surface, sounds mind boggling that you'd be able to do both of those jobs. How did you do it?

Haddow:

The idea was that we were going to do a very short transition. We already had developed a list of candidates that would be highly qualified to accept the HCFA position. So my job was going to be a two month, outside three month, kind of window. The problem we ran into was a lack of focus by Secretary Heckler on looking seriously at the candidates which created a delay. When we finally got her attention, she didn't like any of the applicants for a variety of reasons, none of which we could ascertain with any certainty as to why. And so this thing just kind of dragged on. After I left that position, we had another Acting behind me. That was solely because of the turmoil resulting from Secretary Heckler being invited to take the Ambassadorship in Ireland. There was a bit of transition issue there. She was distracted by, obviously, the pressures that were building between the White House and her that led to that change in her position.

Berkowitz:

So how about the HCFA job combined with your job for the Secretary...I am trying to picture this. I picture you in the Humphrey Building, and maybe having another office that would be the HCFA office and also in the Humphrey Building?

Haddow:

Just downstairs. Yes.

Berkowitz:

Did you divide up your day systematically or more kind of ad hoc?

Haddow:

Mostly it was determined by what was happening. I spent a lot of time out in Baltimore, at least early on, because HCFA's operations are based there.

We were just doing the political side of it in Washington. But the senior staff was in Washington. It was interesting because, just after I was appointed as the Acting, we had a big issue that involved some concerns about information that was going to be provided to a member of Congress about something that was going on at HCFA. I had sat down in the conference room. I arrived late because I was in a meeting with Secretary Heckler. When I walked in, there was only one seat left at the table in a crowded room and there were people standing all over the place.

Patti Tyson, who was an assistant to the Secretary, was well known in the Department and well known to the people there, had saved a seat for me. So you would think that anyone would figure out that she was saving a seat for someone other than just a run-of-the-mill person. When I sat down, we were in the middle of this debate and I told them my decision, and the fellow that was articulating his view that we should release this information to a member of Congress who had no business getting it in the way that he was asking for it, he said, "Well that doesn't make any sense." And he used a fairly strong invective against me that ended with, "and I don't know who you think you are?"

I was sitting there stunned by it and Patty Tyson said, "He's the Acting Administrator." [laughs] So the guy chased me to the elevator and apologized. But, it was my introduction to the way that this operation worked. The thing I like about it, frankly, was that there was healthy debate. People were willing to just say what they thought, which I thought was fine. Part of that was because they didn't like the Reagan Administration, so they wanted to stick it in our eye any time they could. But from those discussions -- and I opened the door to it -- we actually got to a pretty good place, in terms of finding the right policy decision in most cases.

Berkowitz:

What was the issue? Do you know? You said that it was about releasing information --

Haddow:

There was a request made by a member of Congress about a decision at one division at HCFA and it was a fishing expedition. Our argument was that the member of Congress should specifically state what he wanted. When he came back, he said, "Well then I want to come down and meet this HCFA person" -- a specific staffer, who was petrified at the thought -- "and go through the files." And we said, "No." You can come to a conference room, we will invite that person in, and you tell us what files you want. That was my decision. You tell us exactly what you want, but we're not going to open up our file

drawers for you to just have a fishing expedition. That's not going to happen. And this was a very liberal member of the Congress from New York that we knew was just going to use it for political purposes and whatever issue that he thought was important. This dealt with the DRG limitations on when we release patients from the hospital and so he was convinced that there was some document that would show that HCFA knew --

Berkowitz:

-- That there was a policy to release people.

Haddow:

Right. So that was the issue. It was sort of an interesting thing. I ended up in front of the hearing with Senator (John) Heinz (R-Pennsylvania) on that issue. Part of the process is to encourage hospitals to get patients out the door, not let them sit there. That was our thinking behind it. And of course, there are abuses that crop up, right? Hospitals say, "Get them out of here now," and Senator Heinz, a good Republican, although not --

Berkowitz:

-- He was on the Committee on Aging.

Haddow:

Right. That's right. And I was called to a hearing because they had done an investigation into the same issue and they had documents that showed, as an example, a woman in, I think it was in North Carolina, who had been discharged from the hospital and that she had gone home and died of a heart attack. She had been admitted for a cardiac issue. And so, the allegation was that we were killing people. And when we looked behind it, we found that as the patient was exiting the hospital, in a wheelchair with a nurse accompanying her, she complained of chest pains, at which point the nurse said, "I need to take you back to the cardiac for evaluation." The woman refused and said, "No, I've been discharged, I'm going home." And the nurse said, "No, I'm obligated to keep you here." And so, the woman signed a release and her daughter was with her when this happened and witnessed it. They sent her home; she died a couple days later. The daughter then alleged that we had screwed up. The hospital had screwed up. Now once Senator Heinz heard the facts behind the allegation, we became much friendlier.

Berkowitz:

You quickly established that you are both from Pittsburgh?

Haddow:

Exactly. It was interesting; it was a very contentious hearing in the afternoon and we were on MacNeil/Lehrer that night. And it was like a love-fest that night, whereas in the afternoon it was a very tense thing. It ended up, after I testified, I went in and spoke with him in his office and we made peace on it. His staff had done, in their view, an investigation, and I just showed him where some of the problems were with that.

Berkowitz:

Of course Senator Hatch was on Health and Human Services Committee at this time, too.

Haddow:

That's correct.

Berkowitz:

So that must have been another avenue you could use, on things like Medicare and Social Security.

Haddow:

Orrin was more interested in my helping him than him helping us, but you know that's the way it is [laughs]. Once you work for Hatch, you're conscripted for life, and that's the way it is. But, yes, it was very valuable to have that connection because he was very helpful.

Berkowitz:

So you left this world of HHS in 1986, a Congressional election year. What was behind that decision?

Haddow:

That's correct. There was a transition of administrations and Reagan was out and Bush was coming in.

Berkowitz:

I thought you left in 1986, right?

Haddow:

I did.

Berkowitz:

So that would have been --

Haddow:

Well, I'm sorry, Heckler left.

Berkowitz:

Yes. Okay.

Haddow:

I'm sorry, you're right; I pre-dated that a little bit. When Heckler became the Ambassador to Ireland, then it was a transition out as the new Secretary came in.

Berkowitz:

That was Secretary Sullivan, who obviously had his own people.

In this long career that you have had subsequently in the private sector, is healthcare one of your priorities still?

Haddow:

Sure. I have clients over the years; I worked for 17 years for Mylan Pharmaceuticals, one of the top generic houses in the country. After I left HHS, they were one of my first clients. Now I had met with the folks at Mylan when I was the Chief of Staff where they had come

in and made allegations that the FDA was discriminating against them for their applications which was the precursor to the generic drug scandal. And I did some analysis on a specific drug at FDA that involved a clinical trial they had done in generic. They had done some extra work in order to get a superiority rating over the existing therapy.

The therapy was Dyazide, which is a anti-hypertensive which uses a compounding of drugs in order to lower your blood pressure but restore the potassium levels to maintain your heart rates and all that. Their belief was that they were being discriminated against because they had done all the extra work and the promised superior rating had not been forthcoming, and they weren't getting approved. And, as it turned out, they were absolutely right. I called Frank Young in, he told me the Director of CDER was not going to approve that drug, he didn't like the drug. He didn't think Dyazide should have been approved in the first place. So he wasn't going to approve a successor drug to it--even though they had met all the qualifications, done everything and it was approvable.

I helped them sort through that problem. That was the year Reagan was running against Mondale, and Mondale suffered from high blood pressure and one of the outcomes was he always had bags under his eyes. There actually was a reporter that called me and said, "The word is out that you are holding back on approving a drug that is more effective so he keeps the bags under Mondale's eyes." [laughs] I mean this is the culture of Washington, right? We laughed about it because we had been fighting for six months with the FDA to approve that doggone drug.

When I left, Mylan hired me and then we dug in and found out that the corruption at the FDA was far worse than anyone thought. There were payoffs being made by competing drug companies and that sort of thing. In the end many of the FDA people went to jail. The generic drug industry was shut down for three years. But I got immersed in that investigation and in the policy framework and learned much more about the FDA than I ever learned when I was at HHS.

So, yes, I've stayed in touch with healthcare related issues, pharmaceutical issues. I'm working with a company that is working on research to fight antibiotic-resistant super-bugs; I'm trying to help them sort their way through the policy maze to make sure that we get the best environment for stimulating that kind of work. I've done that over the years.

Berkowitz:

So how about work on Medicare/Medicaid? Not so much?

Haddow:

Not so much. My background on those has been invaluable to me because I've had a couple clients where someone will say, "I need to get reimbursed for this drug and under the national coverage decisions, they haven't done it right and they've done local governing decisions which are in conflict." So I have been able to go in occasionally and work on those kinds of issues. But most of the work is up in the Congress because the CMS is pretty much insulated from lobbying government relations work by companies. Usually lawyers go in and do that kind of work where they are negotiating those things. So I have not done a lot at CMS, but mostly in the Congress.

Berkowitz:

That's why CMS is in Baltimore.

Haddow:

[laughs] I think that's right.

Berkowitz:

Well, very good. Thank you so much for doing this. Really appreciate it.

Haddow: Glad to. Thank you.

NATIONAL
ACADEMY
OF SOCIAL
INSURANCE

Interview with Michael Hash

Washington DC on May 11, 2015

Interview conducted by Edward Berkowitz

Transcript edited for clarity.

Berkowitz:

Today is May 11th, 2015, and we are at the National Academy of Social Insurance Headquarters in Washington, and I'm talking to Michael M. Hash. Why don't we start just talking a little bit about your background? I see you're educated at Washington and Lee, and you went to school also at Vanderbilt. Are you from the south?

Hash:

I am. I grew up in Nashville, Tennessee. I went away to college and came back and went to graduate school at Vanderbilt.

Berkowitz:

I see. So Vanderbilt was also at home for you?

Hash:

Yes, it was.

Berkowitz:

Did you actually live in Nashville?

Hash:

I did -- all the way through my graduate school time. I grew up in the west end part of Nashville. I could walk to Vanderbilt as a kid. My family, however, was dyed in the wool University of Tennessee fans. They all went to U.T. except for me, and so Vanderbilt was the worst possible place you could go [laughs].

Berkowitz:

I see. Your career that I know about begins in 1973 when you worked for the American Hospital Association. Is there something I should know before that then?

Hash:

I worked for about 18 months for the Clerk for the House of Representatives. That was actually my first job in Washington. I started there in 1969 and was there about six months. I had to go into the service. I was gone for two years, came back, and was there another year and a quarter, and my job was something which now has been made obsolete, pretty much. I was the Assistant Tally Clerk of the House of Representatives. I was the one who recorded votes; this was prior to what's now known as electronic voting. There was a big sheet listing the Members, and you recorded them as they voted.

Berkowitz:

I see. Did you have one of the fancy hidden offices like the Speaker has?

Hash:

It wasn't fancy, but it was hidden [laughs]. It was in the Capitol up on the third floor, across from the gallery.

Berkowitz:

So, eventually you do get to the American Hospital Association?

Hash:

November '73.

Berkowitz:

And how did that come about?

Hash:

Well, a colleague of mine working in the Clerk's office had taken a job there about a year before, and I had run into him, and he said he was having a great time, and they were looking for somebody to be in the Legislative Representation Office, and I said, "Well, gee, that sounds interesting." I had no background in health or healthcare policy from school. I was in political science, but not in any way involved with healthcare policy. So, I went in, and he got me an interview. I had the interview, was hired and stayed there seven years and ended up running the Washington office of the American Hospital Association.

Berkowitz:

Interesting. If I can remember those years correctly, when Jimmy Carter was President, one of his big things was hospital cost containment. Was that a big issue for you?

Hash:

It was a huge issue. It was the issue of my time there. Joe Califano was Secretary of the Department of Health and Human Services -- then called Health, Education, and Welfare -- during that period, and there had been an initial effort on the part of the Carter administration to pursue a national health coverage bill which had pretty much fizzled out. Kind of a sequel to that was Joe Califano's view that there should be a control on expenses, particularly hospital expenses because of the large proportion of national spending on hospital care, and so he pursued quite vigorously the hospital cost containment legislation.

It eventually also failed, as you may recall, and it was succeeded by an industry initiative

that was known as “the Voluntary Effort,” which was a coalition of the AHA, the Federation of American Hospitals -- which is the investor-owned trade association of hospitals -- and the Catholic Health Association. Actually the AMA was involved as well. This was an effort designed to say we can -- without violating anti-trust law -- come together and adopt best practices and develop more efficient ways of organizing and delivering hospital services and achieve much of the same ends that the hospital cost containment bill was designed to do, which was control the growth of hospital spending.

Berkowitz:

That’s interesting. Sort of like what Hubert Hoover wanted to do in the Department of Commerce, a best practice trade association.”

Hash:

Right; you’re exactly right.

Berkowitz:

I see you’re a Democrat, looking at your subsequent activities?

Hash:

I am. I have always been a Democrat.

Berkowitz:

I’m curious about the American Hospital Association. Was it their policy to have both Democrats and Republicans, so they could talk to everyone?

Hash:

Yes, there were employees or staff of both persuasions. In the 1970s, it was a different time. There was much less polarization. Congress, with a few exceptions, had been under the control of Democrats since the ’50s. The House had been continuously Democratic. And so I think, regardless of the industry or trade, most organizations in those days when they hired people to do representation hired a lot of Democrats because Democrats were running the show.

The other thing different about that time and that certainly made it reasonably comfortable for me, was that AHA, and other hospital groups as well, long supported a national insurance coverage program, which they had introduced beginning in about 1971 or 1972. Al Ullman, who eventually became Chairman of the House Ways and Means Committee from Oregon, was the lead sponsor of that legislation that was known as HR1 in a number of its manifestations. There were other bills that Ted Kennedy and labor people had like the Kennedy-Corman bill and the Kennedy-Mills bill which were aimed at being a compromise between labor and others. AHA was in the forefront of advocating expansion of coverage, primarily insurance coverage at that time through employment. AHA also supported Medicare in 1965 when the AMA was elsewhere.

The early 1970s was a time of progressive views, I think, among the hospital community. If I had to make a general observation about the evolution of politics in the hospital sector from my vantage point, I think hospitals have become more conservative over time. Their boards have become much more dominated by people of the other political party

persuasion, Republican. I think the way that manifested itself in terms of public policy advocacy by AHA is that they became somewhat more cautious as opposed to being more out front and more aggressive in their advocacy of various kinds of health policies. I attribute some of that to the fact that despite a lot of rhetoric to the contrary, hospitals have done reasonably well over the last 30 or 40 years. They've become -- as they always were -- major employers, and their executives have become some of the most highly compensated people in the country. Oftentimes income can be correlated with political persuasion.

Berkowitz:

Did an organization like the American Hospital Association hire somebody, say from Arkansas, to talk to Wilbur Mills?

Hash:

I think really it does boil down to you got hired because you had the contacts because you'd worked on the Hill. In my case, it's still quite a mystery to me how I ended up getting the job to be quite honest because I didn't fit the bill of having all those contacts. I knew how the Congress worked. I knew some of the members because I worked on the floor for 18 months-- but only in a very superficial kind of way. But I think a lot of the people that were colleagues of mine back in those days were people who had worked on the personal staff for key members or on the committee staffs. And in those days, committee staffs were very small relative to today and also people on committee staffs tended to make a career out of working for the Congress and retiring from it. Of course, that's no longer the case either.

A lot of the people who got the kind of job that I started out with had been LAs, legislative assistant's, for perhaps Wilbur Mills or Ted Kennedy or some other leading member of the committees of jurisdiction. That was also key. If your interest lay in health policy, then of course you would be interested in people who could connect to the people who were serving on those committees. In those days, the committee deliberations were critical. Things had been ironed out one way or the other even before a bill came to the floor.

Berkowitz:

I'm missing the years between 1980 and 1990.

Hash:

In 1980, I joined a brand new consulting firm that was created by three fellows who actually had very close association with the Medicare program. Two of them were part of the original staff group that put the Medicare legislation together under Wilbur Cohen. They were Bill Fullerton, who at the time worked for Social Security, which was the agency that was originally running the programs and Irv Wolkstein. In addition to those two, there was Stan Jones who had worked for Ted Kennedy. They formed a firm originally called "Fullerton, Jones and Wolkstein."

Stan Jones, in 1980, after about two years, decided to head up the Washington office of the Blue Cross and Blue Shield Association, which opened up an opportunity. I had been working with Irv because he had worked at AHA for several years before -- he retired (from SSA), worked for AHA, and then went together with Bill and Stan to form what ultimately

became Health Policy Alternatives. So I was the fourth person to go there in 1980, and I stayed with the firm until I went to work for Henry Waxman in May of 1990.

Berkowitz:

What kind of stuff did you do for Health Policy Alternatives?

Hash:

Well, basically public policy analysis and advice, strategic advice. The firm's original goal was to create a place with more senior people who could offer analytic services somewhat analogous to the Congressional Research Service. There was a view among the founders that there was a market for impartial, objective analysis in the private sector, and that was how the firm was started.

One of their original tenants was they were never lobbyists in the formal sense of the word. They didn't actually go with clients to Capitol Hill or to the agencies, but they prepared people, and they did analysis that would help to support the arguments that were being made by a client. The clients ran the gamut from the hospital associations to medical specialty groups and the like. We had a major client in AHA, but we worked for three or four hospital associations. We worked for several medical specialty groups. We worked for some drug companies.

We worked for pretty much the broad spectrum of organizations involved in the financing or delivery of healthcare including insurance. Blue Cross Blue Shield, Aetna, United -- a lot of those were clients of ours. The reason we were able to do that is that we were not out there with our own advocacy pieces. We were not a place that was particularly known to have a bias or a particular focus for our work, and therefore, we were able to handle what would be likely be conflicts by the fact that we weren't really out there saying to somebody one day one thing and something quite contradictory the second day because we didn't do the advocacy piece. The firm's still going, and you'll see in my resume I went back a couple of times after my other jobs ran out for various reasons in the public sector.

Irv Wolkstein was a great mentor of mine and Bill Fullerton, as well. Both of them are no longer with us, but they were there at the creation of Medicare and Medicaid. Back in those days, in the '60s, for example, on Ways and Means, and I'm sure it was true in Senate Finance as well, the staff might have been one person. So when they were getting serious about doing Medicare under President Johnson's leadership, this group of probably five or six people led by Wilbur Cohen, basically performed the staff work for Wilbur Mills and the Ways and Means committee.

Berkowitz:

Right and you also had CRS (Congressional Research Service) people in a way I don't think they do anymore.

Hash:

They don't do that anymore [laughs].

Berkowitz:

They also used to have the Social Security Administration write some of the committee

reports and stuff, which I know they don't do anymore.

Hash:

They definitely did that. It was a very different model than what exists today, but that's my start. I was very fortunate to have been exposed to these guys who had preceded me and with great success and careers in health policy.

Berkowitz:

So, in 1990 you went to work for Henry Waxman? Had you met him before?

Hash:

I had met him because he was Chairman for many, many years of the Health and Environment Subcommittee of the Energy and Commerce Committee. In my work, I knew him, not well. He had a terrific staff, led by a woman named Karen Nelson, and I knew Karen before she even worked for the Commerce Committee. Previously she worked for the Finance Committee and when I was at AHA I got to know her. She actually hired me, with Waxman's acquiescence, in 1990.

I was the Medicare staff person. In the house, it's a little complicated about jurisdiction over the Medicare program. Basically Commerce shared jurisdiction over Part B, the physician and out-patient services and Part A was solely in the jurisdiction of the Ways and Means Committee in the House.

Berkowitz:

I've always been curious about that. Somebody must have taken that stuff away from Ways and Means.

Hash:

Well, it was before my time. The Committee on Energy and Commerce had, historically, the major responsibility in health policy. They were the committee, for example, that started the Public Health Service, which goes actually all the way back to the beginning of the country. They were the committee responsible for the Hill-Burton Act after World War II. Much of the public health policy of the federal government legislatively emanated from the Energy and Commerce Committee. At the time that Medicare was under consideration, there was, as there always is, especially with something big and new, some jockeying around about who was going to have the responsibility.

The decision was made on the hospital part A side, to graft it on to the Social Security statute that was already in place and to finance it, essentially, with an add-on to the FICA tax, which was squarely in the domain of the Ways and Means Committee. But part B, as you well know, was general revenue financed, and I think that people in the Commerce Committee at the time said, "Well, this is an appropriated sum of money; it's not a dedicated tax like the FICA tax, and therefore, since it's for this public health purpose, it really should be in the Commerce Committee's jurisdiction." And, of course, as often happens, the compromise was, "Okay, well, you can have that, but you're going to share that with us because we're going to have both." I'm sure it was somewhat more elegant than that, but that was my understanding of how it got split that way. It had to do with the source of financing for the program.

Berkowitz:

Right, and of course, with Medicaid, I guess nobody could see that that was going to become such a huge deal.

Hash:

As you know, it was an add-on at the very end of the process. It wasn't something they started out to do, and it got done right toward the end.

Berkowitz:

I was just thinking Mr. Dingell was certainly there in 1965.

Hash:

He was in the chair when the bill was on the floor. He was in the chair, chairing the House session that passed the bill.

Berkowitz:

That was, I think, Wilbur Cohen's doing in part.

Hash:

Yes.

Berkowitz:

When I think about Congressman Waxman, the first thing that comes to mind is Medicaid because I know he worked on these expansions of Medicaid. But you're working really on Medicare Part B.

Hash:

I was, and I was there shortly after Medicare had moved to the RVS (Relative Value Scale) schedule for physician payment. That was actually done in the amendments of '89, and I came in the spring of '90, and during the five years I was there, almost every year except maybe the last one, we had budget reconciliation bills, and that was essentially the way that Medicare policy got done every year. Under that process they had special, expedited procedures in the Senate where it was always important to have a way to get to the floor without having 60 votes. And with a reconciliation bill you could go to the floor and have it considered without a super majority vote in the Senate, which made things much easier.

The Budget Committee had to authorize the use of reconciliation procedure in the budget resolutions, and back in those days Congress actually adopted a budget resolution every year. Every year, there were instructions in that resolution that created the opportunity to do a budget reconciliation bill.

Berkowitz:

So, let me see if I have this straight. They would say in the budget bill that there's going to be X billion dollars for Medicare over the next three years?

Hash:

Well, more likely, X billion dollars saved from what would otherwise be estimated to have

been spent because, remember, this is all about containing the growth in federal health expenditure, so the instructions would be to the Committees of Jurisdiction in the Medicare program to do savings of X over Y number of years. And then, needless to say, they didn't tell you how to do it. That was the prerogative of the committees of jurisdiction.

Berkowitz:

So, I begin to make more sense out of the Henry Waxman expansions of Medicaid. He must have said, "Ah, there's so much money we could do a little bit of an expansion of Medicaid."

Hash:

Yes. He did what was famously called "the Waxman Wedge," which over a period of about eight or nine years, expanded eligibility for children in low-income families up to -- well, eventually up to 120 percent of poverty, I think. I can't remember the exact numbers, but he didn't do it all in one year. Another budgetary technique was to authorize expansion of programs outside the budget window. The budget window was 10 years. If you had something happening outside the 10-year window, it didn't count against the limitations that were imposed by the budget resolution for that 10-year period. And that's not possible I think any more, but it was once upon a time possible. There were lots of ways to get things done, and Henry Waxman knew all of them and took advantage of them to advance coverage for low income people -- not only children, but pregnant women, breast and cervical cancer patients, and others. There is a very long list of Medicaid policies that he authored and was able to get enacted.

Berkowitz:

I see. Wilbur Mills probably wouldn't have approved this?

Hash:

No, and then, of course, Medicaid as an appropriated program, was solely in the jurisdiction of the Commerce Committee, so there was no involvement of Ways and Means at all in those expansions.

Berkowitz:

I understand that by March of 1998, which is a few years after we been talking about, you were working as Nancy DeParle's deputy --

Hash:

I was.

Berkowitz:

Can you talk about that? How did that came about?

Hash:

Well, in the first term of the Clinton administration, I was working at the Energy and Commerce Committee. That was '93-95. The '94 election, of course, was the time when control of the House turned over for the first time in many, many years.

Berkowitz:
Since 1953.

Hash:

Something like that, and that was the end of my job. I remember it well [laughs] because the Republicans took over the House, and they controlled the budgets of the committees and the slots and so forth, and our staff was quite significant in size as well as in other ways, but certainly in size. There were probably, on the sub-committee of Henry Waxman, probably 10 people, 10 professionals, and when it changed, there were really only two positions left. And one was Karen Nelson who stayed and I think Andy Schneider who did the Medicaid work, and everybody else was let go; I went back to Health Policy Alternatives.

In that period, Nancy-Ann (DeParle) was the PAD or the Program Activity Director at OMB. Her set of responsibilities was basically the programs of the Health and Human Services Department. And actually, she also had some others, but as everybody who remembers in the early days of the Clinton administration knows, there was also another run at national insurance coverage. Nancy-Ann was also very much involved in that effort. When that was first being considered in the early nineties, it took them a year to formulate the bill as you may recall.

Some people thought that wasn't the best strategy, but that's what happened. It finally came to Congress probably in about November of '93. We started working on it, and of course, Nancy-Ann had the kind of role for the administration where she would be there on the Hill a lot working with the committee staffs on that legislation. I got to know her through that period because she was around a lot and then the Democrats lost. I went back to Health Policy Alternatives in '95. She continued on as the PAD until the fall of the second term, which would have been I think in September of '97. The previous Administrator was Bruce Vladeck. Bruce was there for a while before she actually became confirmed.

Maybe a month or so or two after she was confirmed, she called me and asked, "Would you be interested in coming to work here?" I said, "Sure," because I had a lot of respect and regard for her. She's an extraordinary person, and also I had not had the opportunity to work in the executive branch before, and I thought this would be a really good opportunity to continue public service. And as often happens, it took a while to get all the clearance stuff done, and I didn't actually report until I think sometime in April of '98. Also I had some loose ends to finish up where I was working, and so it took a while. But anyway, I got there and it was because of Nancy-Ann.

Berkowitz:

Was there a Tennessee connection or not?

Hash:

No, and people always ask me that. It turned out that in the process of getting hired, she discovered I was from Tennessee, and she said, "You're from Tennessee?" And I said, "Yes," because we somehow had never talked about it, and she said, "Well, I'm from Tennessee." She's from a small town in Eastern Tennessee near Knoxville, and I'm from Nashville and we're not the same age by a long stretch; we didn't know each other until we

met here, until I met her when she was working at OMB.

Berkowitz:

I see. When you were in that time at CMS or HCFA, one of the things you worked on was President Clinton's nursing home initiative, which I know nothing about. Can you tell me a little bit about it?

Hash:

As is true today, maintaining quality services in long-term care is a real challenge. Medicare has a relatively limited window in long-term care; there is just a post-acute, skilled nursing benefit for 100 days. After the first 20 days, you have to pay a co-pay if you are still qualified for skilled care. The benefit was designed for post-acute rehabilitation services primarily, for after surgery and things like that, and clearly not as a long-term care benefit. Whereas, as we all know, the Medicaid program historically has been the source of coverage for long-term care facilities, for people who become impoverished.

In the Clinton administration there was a desire to work more closely with the advocacy groups. There were several very important nursing home consumer advocacy groups who had also championed nursing home reform legislation through the Congress, which gave the executive branch and HHS much more authority to oversee and set standards for the long-term care industry. Nancy-Ann and the President himself were very interested in having a much more robust program in the area. The stories about things going wrong were terrible and were unacceptable.

There is no need to rehearse those, but the poor care that some people were subjected to is just appalling, so there was a very strong push to do something about enhancing the capabilities of the oversight. The difficulty always was the law; the nursing home reform law required that every nursing home be inspected once a year by either federal or state inspectors who are under contract to the federal government. The federal government was paying for the cost of these inspections. States had successfully avoided taking on that responsibility, and so there are federal inspectors who, in some states, did the nursing home visits. In other states, it was done by state employees who were basically financed by a grant from HHS to support their activities. In those days -- and I assume it's roughly the same now -- there were about 17,000 nursing homes across the country. There was always difficulty getting an appropriation to support the cost of these inspections.

For various and sundry reasons, improving the caliber of training of the inspectors, strengthening the nursing home survey instrument, getting all of that done in regulations was very controversial, and the nursing home industry, which had a very strong presence and still does I presume in Washington, was not always the most cooperative group of people to work with us. But I think we made some progress.

One of the things we did was trying to be much more transparent about the results of the survey. Advocates have complained for a long time that even though the survey instruments and the results of surveys were supposed to be available upon request, it was difficult for residents and their families to actually get the information. One of the things we did was require a much more public posting and visibility and accessibility of the reports including all the deficiencies, if there were any, and what they were and what the timetable

and plan for correcting those deficiencies was. It was those kinds of things that we did to try to increase the quality of long-term care in these nursing facilities.

Berkowitz:

I see. Was Bruce Vladeck involved in it?

Hash:

He started a lot of this in his tenure before Nancy-Ann and I got there, but certainly it was a Clinton administration priority. As a result, when I got there Nancy-Ann had asked me to head up the efforts at HCFA related to that. And so I spent a lot of time with the nursing home industry, a lot of time with the advocacy groups, a lot of time going out on the road. The survey people are critically important. We were trying to increase their training and effectiveness and to raise their morale in terms of the importance of what they're doing and how critical it is to the health and welfare of the people who are being served in these institutions.

Berkowitz:

Moving to the time that you became Acting Administrator in 2000, how did that come about?

Hash:

Well, Nancy-Ann was in the process of having a second child. The child was born in September of 2000. She decided that since the administration was coming to an end and it was likely that she would be leaving at the end of the administration, it made sense to leave then. I think it was only a period of about three months that I was in the role.

Berkowitz:

So, it turns out that Mr. Gore didn't become president, and the second Mr. Bush became president.

Hash:

Right. I went back to Health Policy Alternatives.

Berkowitz:

Skipping over the Bush years now, I wanted to make sure we talked about the Affordable Care Act. As I understand it, you were very close to the process of producing the Affordable Care Act in 2010. How did that come about?

Hash:

Nancy-Ann, in March of 2009, had been asked by the President to head up the White House office of health reform because he had decided to give priority to expanding coverage for all Americans. And Nancy-Ann in March agreed to take on this role. In March, she called me and said, "I'm taking this job at the White House at the request of the President. Would you come and be my deputy?" And I said, "I don't know. You know, I think it's maybe a little past my time to do something like this."

And she said, "Oh, no, no, no, no, no, one thing I've always said is that when opportunities come along, step outside your comfort zone and take them on because that oftentimes

leads to the most rewarding experiences.” She was spot on right. I arrived in early April of 2009 at the White House. We had a very small office. There were three of us, four of us, I guess all together. We had a communications person and another person who worked with me and Nancy-Ann and a lawyer, and that was it. And of course, we also had a group of people at HHS who were working on this with us.

Berkowitz:

Jeanne Lambrew?

Hash:

Jeanne Lambrew was at HHS at the time and headed the office of health reform that Secretary Sebelius created at HHS. Therein lies some of the confusion because there were two offices of health reform, one at the White House and one at HHS.

Berkowitz:

Now this office of health reform that was at HHS, is that a part of the Office of the Secretary?

Hash:

It is.

Berkowitz:

So, it's just an ad hoc, temporary thing.

Hash:

Yes, but it's still in operation today. It is housed in the Office of the Secretary. But, anyway, back to my time.

For a little short of two years, I worked at the White House with Nancy-Ann, basically working with the staffs on Capitol Hill, in the Congress, in the House, in the Senate to develop and process the legislation that became the Affordable Care Act. I was very closely involved every day, and it involved drafting; it involved going up to the Hill, spending time with the committee staff to work out agreements and details of what became a 2,000-page bill when it was finally done. That was how I spent the 18 months pretty much. And then, of course, it was enacted March 23rd of 2010.

Berkowitz:

And were you there?

Hash:

I was there, absolutely, in the East Room of the White House -- it was a highlight of my career. Actually, just as long as we're doing history, the highlight of all of this for me was the night it finally passed the Congress, which was something like a Sunday night before the President signed it on Tuesday into law.

The last vote took place around midnight and I was up in the gallery in the House. I was going to go home because it was, by then, 12:30 or something like that, and a colleague of

mine said, "Oh, aren't you coming back to the office?" meaning to the White House, and I said, "Are you kidding? I'm going home. I'm going to bed." And she said, "Oh, no, no you have to come back. You have to come back."

I thought, "This is sort of strange." So I went back, and it turned out that the President invited us up to his quarters at 12:30 in the morning to have champagne and hors d'oeuvres on the Truman balcony with him. There were maybe 15 or 20 of us. It was magical. It was a wonderfully beautiful spring night, and was everything you would want an occasion like that to be. There we were, this little merry band of folks having a grand ole time with the President at 1:00, 1:30 in the morning. I think most people would say, "Well that must have been the highlight of your professional career," and I would say, "Yes, that was." It was quite a heady moment.

Berkowitz:

Had you ever been on that floor of the White House before?

Hash:

No, never. His wife was away; his kids were away, so he said, "Ah, just wander around, look in all the rooms, take a look." And we did. We went to the Lincoln bedroom and a bedroom called the queen's bedroom. They have a kitchen, and they have a family dining room, and they have wonderful sitting room. And then they have this oval or semi-circle room that frames the balcony that's on the south side. There were people with trays of champagne, passing hors d'oeuvres around, and it was quite, quite incredible.

Berkowitz:

The President could just call up at any hour and say, "Send up the champagne."

Hash:

I think he could, and I think any President could [laughs]. There's a staff there all the time. I'm sure someone had been thinking about this in advance, and I'm sure he probably thought, "This can't possibly go on until midnight." But of course, you can never predict the schedule in the Congress. It went on and on and on. And unbeknownst to us that he was planning any kind of a celebration, but he was. And then two days later there was the signing ceremony.

Berkowitz:

Was Secretary Sebelius there that night?

Hash:

She was not there. It was just White House people. It was Nancy-Ann and me and the folks in our office and some of his staff like Gene Sperling who was at the time the National Economic Advisor and the head of the Council of Economic Advisors. It was the senior staff at the White House who had had some involvement in this because not everybody at the White House was working on this.

Berkowitz:

The President obviously must have felt good about having passed the bill. Was there any conversation about, "Well, Mr. President, you're the first person since Johnson to

succeed.”

Hash:

Oh, yes. Everyone was humbled by the fact that we were a part of this effort that had previously failed. The President’s remarks to all of us really brought all that home. His message that night was, “No matter what you do the rest of your careers, this will be the hallmark of your public service careers.” And a lot of them were younger people, much younger than me. And I think he was right. These kind of things come along only infrequently in our history -- these sorts of watershed public policy moments. This was clearly one of them, and I think helping to make history is a pretty heady experience for anybody.

Berkowitz:

When we talked to Nancy-Ann about the experience that she had working on the bill, she said, “Oh, I spent all my time on the Hill.” It sounds like you did, too.

Hash:

I did. First of all, we were working on both sides -- the House and the Senate -- and frequently the sessions we had were on a daily basis, including weekends. This was a very intense process; it involved joint meetings of House and Senate staff that we helped to staff. And then there were oftentimes just Senate meetings and House meetings.

If you wanted to keep things on track, you had to have a strategy and a plan: “Okay, tomorrow we’re going to talk about this, and the next day, we’re going to talk about this.” You had to have an agenda, and you had to have somebody really pushing the agenda. Nancy-Ann was leading that effort, and even though everyone was trying to respect each other’s role because, of course, the Congress has a key role in all of this as well.

But yes, we got up there a lot, and the process was very mercurial. It was up and down, and up and down, and then probably the lowest point of the whole process was the election of Scott Brown in January of 2010.

Berkowitz:

That’s the Senator from Massachusetts?

Hash:

Correct, and as a result, as you know, it changed the vote calculation in the Senate. This legislation was proceeding not under budget reconciliation authority; it was under what you might call a regular order. That meant, in the Senate, just to proceed to consider the bill, you had to have 60 votes, and then on any of the amendments or anything like that, 60 more votes. So, once you didn’t have 60 votes in the Senate, it became questionable about how the enterprise was going to be brought to conclusion.

Berkowitz:

The people who work in the White House are politically very smart and savvy. They didn’t see that coming -- that Scott Brown was going to win the election?

Hash:

I think not until probably mid to late December, and the election was held around the 18th or 19th of January, I think. And, not surprisingly, the people working on the Affordable Care Act certainly would not have been privy to exactly what was going on in the campaign in Massachusetts. Perhaps some were, but information began to circulate that the polling in the race was not looking very favorable, and it didn't get better. Before the election, it was easy to imagine that (Martha) Coakley was going to lose. But I think everybody thought, until the very end, that it would be very close. And it was somewhat close. I forget what the margin was, but obviously she didn't win.

Berkowitz:

Thinking about the development and passage of health reform, are there any people that might be called the unsung heroes? Any member that maybe doesn't always figure in the story, but in fact was vital to your work?

Hash:

A member of Congress?

Berkowitz:

Yes.

Hash:

Well, I would say, without hesitation, that the most significant player in the process in many, many ways, was Nancy Pelosi, the Speaker of the House. You have to remember the situation when it finally got done. It was done in two steps because of the lack of 60 votes in the Senate.

The original bill that had passed the Senate in December of 2009 was in the House waiting. The original notion was the House would take it up, but of course alter it because there were things they were interested in doing; then subsequently there'd be a conference and there would be a vote on the conference report. Of course, that couldn't happen after the Kennedy seat was taken by Brown. What Speaker Pelosi was able to do, which is not very far from a miracle, was to get the House members on the Democratic side to agree to pass the Senate bill exactly as it passed the Senate.

Berkowitz:

So no conference was necessary.

Hash:

No conference was necessary. Even though there were many, well some, features of the Senate bill which some members of the House were not at all happy with. And the somewhat surprising thing was it was possible to create a reconciliation bill that included a limited number of changes to the Senate-passed bill, so that the way it happened, procedurally, was the House passed the Senate bill and immediately passed the budget reconciliation bill, which in some instances amended the Senate-passed bill.

I can't emphasize enough how difficult it was to get the House to do that. And they did. I don't mean to take away from Senator Harry Reid, who of course was Majority Leader in the Senate, and who was totally supportive all the way through, and who also held the

Democrats in the Senate all together, and that was no small feat in itself. But the House was faced with the most challenging procedural circumstance in the face of policies which they would have wanted to alter but could not.

If ever there were an example of people rising to the occasion of not making the perfect the enemy of the good, it was the day in the House of Representatives when the ACA was passed. I watched Speaker Pelosi working with the members, right up until literally the time of the vote. And she did a Herculean job of holding the caucus together and getting nearly every Democratic vote in the house -- as it turned out, we had about a one-vote margin. She got every vote she needed to pass the bill.

Berkowitz:

Moving forward to June of 2012, you became the Acting Head of the Center for Consumer Information and Insurance Oversight, which is part of CMS?

Hash:

Yes.

Berkowitz:

And were you still working in the White House Office of Health Reform?

Hash:

At the end of 2010, in January 2011, I went back to HHS. From a technical point of view, originally when I first went to the White House in April of 2009, I was an employee of HHS, but I was assigned to the Office of Health Reform at the White House.

It's surprising to many people, but the White House is not overrun with money to hire people [laughs]. In fact, it's a pretty lean budget there, certainly for staff. And so at the end of December, I had been there a year and eight months. And usually assigned positions are not supposed to be more than a year or two without going back to the home agency for at least some period of time and then maybe being reassigned again. And at that point, Secretary Sebelius, whom I had gotten to know because she was very closely involved in all this, asked me if I would come to take the job at HHS as the head of the HHS health reform office because Jeanne Lambrew was taking the job as a deputy of the White House Domestic Policy Council to lead implementation efforts there.

Berkowitz:

Jeanne Lambrew moved up because Nancy-Ann DeParle left?

Hash:

Yes. Nancy left that office and the White House decided that to close the office of health reform and move the responsibilities to the DPC led by Cecilia Munoz, who is still there in that role. And Jeanne Lambrew, who had been in my job at HHS, went to become an assistant to Cecilia on the Domestic Policy Council with responsibility for oversight of the Affordable Care Act implementation from the White House. She's there now and that's her role there now. So, I went back to HHS, and for three years -- from January of '11 until June of '14 -- I was the head of the HHS office of health reform.

Then there was this little detour. I didn't actually give up my health reform job, but I took on the job of Acting Head of the Center for Consumer Information and Insurance Oversight, the CCIIO. The previous head left the government, and the Secretary wanted to do a wide search for people with certain credentials, particularly insurance regulation and so forth, to take the job. Secretary Sebelius was an insurance commissioner previously to being Governor of Kansas.

So in the meantime, they needed somebody to oversee the office. I was asked if I would do that until they got a permanent replacement. And so I did the two jobs for, I guess it was for only probably about three months. I don't remember the exact length of time. The guy who came to take the job was Gary Cohen who had worked in the Insurance Department in California.

Berkowitz:

I see. And this is the part of CMS that deals with what?

Hash:

It deals with the marketplaces or exchanges. It is brand new as a part of CMS. When the marketplace first started, it was housed in the Office of the Secretary. But as it grew and its responsibilities and staff grew, it didn't make sense to be running that out of the Office of the Secretary because you didn't want to recreate all of the administrative infrastructure. One of the reasons that it got assigned to the CMS was because there's already a structure there with people who are budget officers, and personnel officers, and all this kind of stuff. Also, it made sense to put it in CMS also because of the close connection between the marketplace activity and Medicaid, which is of course at CMS. That's why the Secretary decided to do it that way. Of course, it made CMS a much bigger place. I think there are some 300 people who work in CCIIO now.

Berkowitz:

Do you know about computers, because that would seem to be part of that job?

Hash:

[laughs] Well, actually at the time I was doing the job, what was going on primarily was getting the policy down -- issues like the rules of the road to establish and operate these new insurance marketplaces. Now granted, a piece of it, which got quite a bit of notoriety, was the website, which was the tool to effectuate choice and enrollment. But apart from all of that, there was all the regulatory development work: setting down the rules of the road for a state if it wanted to operate the marketplace, identifying the terms and conditions that were necessary for them to meet, figuring out the process for review and oversight of their activities, approving a state marketplace plan, working with them in the review of health plans to make sure they met the essential health benefit requirements, that they met the rating requirements, that they met the other standards that were established for the market by the Affordable Care Act.

All of that had to be done de novo because the federal government's role in insurance, private insurance, had been virtually non-existent except for one thing, which was Medigap, the supplemental policies that Medicare beneficiaries can buy if they choose to do so. That's the one area of the private market in insurance, prior to the Affordable Care

Act, where there was federal regulation and federal control of a private insurance market. None of that capacity existed at the federal level, really, until it was created in the task of implementing the Affordable Care Act.

While the whole business of the website and enrollment got the most attention -- and that work was not unimportant to say the least and was certainly a major failure in implementation, which I'd be the first to acknowledge -- that's only part of the story of what was necessary to launch and implement the new marketplaces.

Berkowitz:

So now, I see that you retired?

Hash:

Yes, it was May 30th of 2014.

Berkowitz:

What prompted that?

Hash:

Well, my thought was we were at a place where we had gotten through the first open enrollment period, which had closed in April, and that we were getting ready to start the next cycle of policy and regulatory work for the second open enrollment period, which would begin in the summer. And it seemed to me that this was a time that made sense for a transition. I will tell you that I had decided to do this sometime in March and talked to Secretary Sebelius about it, and she had said yes; she would accept my resignation, but she asked me to stay until the end of May. And then it turned out, about three or four weeks after that, she announced that she was leaving. The honest truth is I had no idea whatsoever. Many people thought that I left because she was leaving, but that was not the case. I had already told her I was leaving before she told me she was leaving.

I think people, especially cabinet officers, keep their own confidences about what their timetables are, or what they want to do. For all of us, it had been over five years, and it was a hard five years in lots of ways. I should say, just to be honest and on the record, in January of '14, I turned 70. I thought to myself, "70, can I possibly be 70?" And then it occurred to me that once you get to be 70, the law of averages says that you never know what might happen, and there are some things I had deferred. For the last five and a half years, I had really had more than a full-time job -- long days, weekends.

Berkowitz:

The type of work you think of young staff people doing.

Hash:

Yes. And I thought I probably had pushed the envelope as widely as I should have. Prudence would say I should let somebody else take over. It was hard in a way because it was the pinnacle of my whole professional career, and I wouldn't take anything for it. I had such a wonderful experience, such great colleagues. Secretary Sebelius was fabulous to me. I couldn't have asked for a boss that I respected more, who worked harder, and one that treated me so well. So it was hard to leave all of that. But when you get to be 70, you

understand there are transitions, and they're appropriate and necessary. In retrospect, I feel very good about having left when I left. It was the right time. I miss the people, but not always the process [laughs].

Berkowitz:

Right. I have one last question for you. You've worked with a lot of the giants like Irwin Wolkstein we've talked about and Henry Waxman, and you've done a lot of things in this field. So if someone said to you, "What's the future of Medicare and Medicaid?" What would you say?

Hash:

I'm very bullish on the future of both programs. I think Medicare remains, among the beneficiaries and the public at large, an extremely popular program. I don't see that going away. Obviously, each generation of people working on Medicare is going to need to make changes, keep it up with the times. The biggest challenge for Medicare going forward is not its existence, I don't think. The biggest challenge is this: can we more effectively organize and deliver healthcare services in a way that maintains or improves quality while at the same time keeping care affordable and sustainable? For Medicare, delivery system reform is certainly the next big challenge.

Most people who are not students of the Affordable Care Act don't realize how much of that Act is actually devoted to delivery system reform. Many parts of the Act have nothing to do with coverage, but with the recognition that -- if you're going to expand access to care, to sustain that over time -- we have to be more creative, more successful at efficiencies in the delivery of care, and improving over time the quality of services that people receive. To me, that's the challenge. It's not that Medicare's going to go away or die on the vine. I think its political strength is entrenched. There are always going to be people who want to change it in various and sundry ways, but the way that it engages with the provider community going forward in terms of the delivery system, that's really where the challenge lies.

Berkowitz:

What about Medicaid?

Hash:

I think the Medicaid challenge is tied in with the delivery system reform as well. It is true that the proportion of state expenditures devoted to Medicaid, and of their budgets, is quite significant. It is, in many states, crowding out opportunities for other kinds of investments in our infrastructure, and education, and so forth. Being able to deliver more efficiently and effectively Medicaid services to its population is really critical because of the challenge of financially sustaining the program.

The Affordable Care Act took a big step in relieving the states of significant expenses going forward for the newly eligible population, but the residual population is not small. There are now upwards of close to 60 million people who are in Medicaid; its enrollment is actually larger than Medicare. It is a big challenge. But I think this is a country that's not going to just walk away from providing access to healthcare for low-income people. I certainly hope that's the case, and we certainly have had a tradition of not doing that. I'm

optimistic that the Medicaid program will be around.

Maybe over time it will become more of a federal program than a state-federal program, as it is today. There's been a long-standing interest among states to do a swap with the federal government. They've wanted the federal government to take Medicaid 100 percent, and they would take on income support, or income maintenance -- TANF (Temporary Assistance for Needy Families), those kinds of services. The states would finance that 100 percent if the Federal government takes on the Medicaid program. I don't know whether that's ever going to happen or not. State participation in Medicaid has always been up to the state. That is to say, they are not compelled to have a Medicaid program. But the financial incentives now are of such a robust nature that many states have seen the wisdom of participating in the Medicaid program, but it's important for people to remember that states are not required to have a Medicaid program.

Berkowitz:

I guess we're going to have to leave these things for the future, but at least as President Obama told you, you were a part of the signature program for your generation.

Hash:

Yes, I think so.

Berkowitz:

And that's no small feat. Thank you very much.

Hash:

Thank you.

Interview with Louis Hays

Washington, DC on April 22, 2015

Interviewed by Edward Berkowitz

Transcript edited for clarity.

Berkowitz:

Today is April 22nd, and I'm talking with Lou Hays. I have a few questions, some of which are follow-ups to our earlier conversation (in 1999), but which center on your days at HCFA. I want to start with some background about yourself which we've talked about before. I read that you were born in southern California, which I take to be Los Angeles.

Hays:

[affirmative] Burbank, California.

Berkowitz:

Burbank, California. And home of Warner Brothers, right?

Hays:

Yes, and Walt Disney.

Berkowitz:

Right [laughs]. And you worked for a while for the county of Los Angeles and went to school in California, but at some point you left to work for the federal government. And as far as I can tell, you never went back to California on a permanent basis, is that right?

Hays:

That is correct. My family -- I had siblings there and parents, but I thought I would go to Washington for a couple of years and then go home, but one thing led to another, and I never did.

Berkowitz:

So it was one of these things that happened rather than a conscious decision on your part.

Hays:

Right. I was a young kid. I was about 27 years old and the idea of going and spending a couple of years in Washington, D.C. sounded really exciting, which in fact it was. But I didn't expect it to become the bulk of my secular career.

Berkowitz:

So you were the acting head of HCFA -- as it was still called -- from about March 1989 to about February of 1990; that's the very beginning of the first Bush administration. But in fact you had gone there earlier, during the Reagan administration?

Hays:

Yes. There were a couple of unique things. First of all, I was a career federal employee; I was not a political appointee. I was actually working in the West Wing of the White House as a career employee, which was doubly unusual. And Bill Roper was the health guy in the Office of Domestic Policy. I think it was actually called the Office of Policy Development.

He ended up getting nominated to become the administrator of HCFA, and because we had worked together and because Bill knew something of my background in running large programs for the federal government, namely child support and part of the Social Security Administration, he asked if I would be interested in going to HCFA to be his associate administrator for operations. And since after two years working in the White House, I was pretty tired of doing staff work, which was not my forte which was running things, I gladly accepted. Sometime in 1986, presumably around the time that Roper was confirmed, I left the White House and moved to HCFA as associate administrator for operations where, again, I was in a position which previously had been held by a political appointee, but I, again, remained a career employee throughout the rest of my tenure with the federal government.

Berkowitz:

I see. So this identity, being in the White House as a federal employee, being in upper levels of HCFA as a civil servant rather than a political appointee, did that affect your interactions in those places? Did they say, "We can't talk to you about this because you're not privy to this political information," -- was there a divide there, or did you just simply do your work?

Hays:

I don't recall that ever being an issue. There weren't political conversations in the sense of being directly, literally, and fully political and therefore confidential and off-limits for a career employee. Obviously there are certain small political considerations, particularly with the programs that were run then by HCFA. But no, I don't recall that being an issue.

It was more of a matter of my subordinate staff. The people who ran the major bureaus under the associate administrator for operations had been accustomed to working with people who were more political and who were definitely non-career employees. So it was a little bit of an adjustment for them to realize that their boss was sort of one of them.

Fortunately, I have -- at least through the end of the Bush administration -- managed to navigate the shoals of working with both Republican and Democratic administrations. I started in what turned out to be the last year of the Nixon administration. I didn't know when I started that it would be for a while under Jerry Ford, and then under Jimmy Carter with the Democrats. Ironically, that's when I got my promotion to the Senior Executive Service, and then, of course, I continued with the Reagan and Bush administrations after that.

Berkowitz:

So you were in your most prominent position during the Reagan and Bush administrations.

Hays:

Yes, but back in the Carter administration I worked pretty closely with Joe Califano, who is one of the ultimate politicians, and we got along fine. It was all business. In those days it was the Child Support Enforcement Program, which happened to be big to Joe Califano because it was big to -- oh, I'm blanking on his name -- the chairman of the Senate Finance Committee --

Berkowitz:

Russell Long.

Hays:

-- Russell Long; so I was accepted into the inner sanctum of the high-level Democrats in the same way that later I was accepted into the inner sanctum of the higher level Republicans.

Berkowitz:

That's interesting. So just to push that point just a little bit further, so even though this is clearly a conservative era if you were writing a history textbook about the Ronald Reagan era and the Bush era, that doesn't really affect you. You're not affected by that general drift in politics? You're just a manager --

Hays:

Yes; it's probably a slight understatement to say I'm just a manager, but yes, I was a bipartisan, or nonpartisan, person. I think it's probably also fair to say that by the time we got to the Clinton administration, I'd been working in fairly high-level positions in three consecutive Republican administrations, so by that point I became more suspect in the eyes of the incoming Democrat administration. But as a practical matter it didn't really matter which party was in power.

Every time there was a new Secretary of HEW, or then HHS, or a new administrator of HCFA, I had to reprove myself over and over and over again. In a way it's really more about who the secretary is than which party happens to be in the White House as to the relationship between the secretary and high-level career or political appointees.

Berkowitz:

That's an interesting point, that the government has to restart all the time which probably has costs --

Hays:

Yes, but it doesn't truly restart in the programmatic sense, but in reestablishing or establishing trust between the political leadership, the overtly political leadership, and, in my case, the career leadership who was in a position that would have normally been held by a political appointee.

Berkowitz:

Right. I guess in your generation of Senior Executive Service people, it was not very unusual to change your job, right? There was a time when -- SSA is a good example, where Arthur Hess and Robert Ball worked just at SSA -- it was less common to change

among various higher level jobs. But by the time you came along, people would shift jobs a little bit, is that right, from one agency to another over the course of their career?

Hays:

I think my experience, both at Social Security and at HCFA, was that most of the senior-level staff just below my level had been there forever and really didn't move around. Somebody would come in as the deputy administrator, say, and be there for a couple years, and then move on. So no, I think the SES staff, at least the ones that I interacted with when I was in government, they were pretty stable.

Berkowitz:

Okay, that's interesting. Let me ask you -- this is somewhat of a policy question, but it's also a management question. You've done a variety of things over the course of your career. You worked for SRS -- the Social and Rehabilitation Service. You've worked on the Child Support Program, which in my mind is a program that was welcomed by a lot of people, not just Russell Long, but others because in that whole field of welfare, the promise of the Child Support Program was always that they would actually get money coming in for child support as opposed to paying out money.

Hays:

True.

Berkowitz:

So that had a crossover appeal between liberals and conservatives. Then you worked for SSA in that time that was sort of dicey time in the disability program --

Hays:

Yes.

Berkowitz:

-- In the 1980s.

Hays:

Right.

Berkowitz:

And then for HCFA. So it just seems to me that you often worked with intermediaries and with complex federal processes, whether they're ALJs, of whom it is said have their own take on the law. And in Medicare you have contractors and fiscal intermediaries that in our previous interview you noted don't always work in tandem doing the same thing. And, of course, the same could be said of the state disability determination services. So I was just curious, did you learn how to manage those types of situations with the interest of efficiency or uniformity?

Hays:

[laughs]. Well, you're right. Much of what I did in my federal career was done through intermediaries, whether it was the state and local government, fiscal intermediaries, or carriers in the case of Medicare, or ALJs. I guess the question is how successful was I?

But that's what it was all about: working, trying to get people to do things or to comply with federal requirements or law or whatever when I didn't necessarily have direct supervision over them. It was both part of the fascination of it and part of the frustration of it as well.

Berkowitz:

I thought maybe you had learned some trick, you know, for dealing with intermediaries, and ALJs, and --

Hays:

[laughs] I'm sure I did, but it was so long ago. I think a lot of it is communication. You're trying to be really clear in what it is you are asking people to do and why. You're trying to provide incentives. You're trying to get people to work with you, not against you. I know those are a lot of platitudes and generalities. I guess if I had any particular strength -- I think my strength then and actually even now as an Episcopal priest is that I had the ability both to lay out a broad vision and communicate a vision, but also manage the details and help make sure that things actually got done.

Berkowitz:

Talking about your HCFA years, one of the things that appear during that time is the Catastrophic Care Act of 1988. Do you have any memories of that, of its enactment, its implementation, and its repeal?

Hays:

[laughs] Yes; more than once I've shared that one of the highlights of my federal service was first being in charge of implementing catastrophic health insurance and then being in charge of de-implementing catastrophic health insurance.

Berkowitz:

[laughs]

Hays:

And it's sad but funny. I still remember going to the signing ceremony at the White House. I have some photographs that people took. Here's this big celebration. And then Bill Roper tasked me with being the implementer and the coordinator.

Probably the biggest -- one of the biggest memories is of trying to get all the pieces of HCFA working together. The people at HCFA were incredibly professional and very hard-working, and it didn't matter whether they were Republicans or Democrats, they basically were very dedicated and did a good job. But the biggest challenge that I remember is related to something that today we take totally for granted. If we have health insurance and we get a prescription, we go to the pharmacy and they seamlessly, while we're standing there at the cash register, run that through a drug intermediary somewhere and it's instantaneously checked and confirmed, and the amount of your co pay is established and they pay their amount, and we don't give it any thought.

Well, in 1988 or '89 that was a big deal. It was in its infancy. And there were two competing ideas. There was the shoebox approach, and there was the automated approach; we chose the automated approach. Whether it would have worked in time if the

program had actually gone into effect, I don't know. But the shoebox approach would have everybody keep all of their receipts and then when they hit a certain amount, somehow they would make their claim to be reimbursed, which would obviously be horribly complicated and inefficient.

I still remember going out to see, I think it was called PCS in those days, one of the first companies that did drug claims somewhere out in Arizona, and that convinced us that we could do this. We could have a point-of-service system. Just thinking about -- It was kind of like the experience that I'd had back in 1975, 1976 trying to set up computer systems to cross-check federal records for purposes of locating absent parents. It was the very beginning of doing that kind of stuff. So that's one of my memories.

And then of course when people figured out that just making drug coverage available would be hugely expensive and that the original estimates were probably off-base, and Congress got cold feet, and they repealed the law.

Berkowitz:

Right. And the -- one of the stories they tell, and I've talked to Congressman Rostenkowski about this, and he said that he went in Chicago to some kind of community meeting and these elderly people came up to him and surrounded his car and were enraged. And the reason they were enraged was this Catastrophic Care Act. Rostenkowski said that was a phony demonstration.

Hays:

I think I've heard that story.

Berkowitz:

Were the people in the agency, like the career people, the people really who have worked forever on these particular programs, did they see that coming? Did they say, "This is not going to fly" or no?

Hays:

To be perfectly candid with you, I don't remember. I think there was skepticism about the cost estimates and what it was really going to cost, but I honestly don't recall that and I can't answer that question.

Berkowitz:

Right. So we actually did get Medicare Part D later. And by then the data processing is quite different, so that makes a big difference. It's a little bit like as if, President Truman had succeeded in creating health insurance, it would have looked quite different than what was passed in the Affordable Care Act. It matters when stuff gets passed.

So let me talk about one other issue that you had to deal with at CMS. One of the questions in Medicare is how much do we pay hospitals? How much do we pay doctors for a particular thing? And in your time it seems like the doctor's side of that was the more pressing. It strikes me that's the ultimate technical issue; it's complex, very hard to get a grip on. Do you have any memories of coming to grips with that --how to think about that

issue, about the paying the doctors, and how to implement whatever measure was developed?

Hays:

That subject was -- at least up until the time that I became acting administrator, and then later when I was acting deputy administrator -- handled by a different part of HCFA. I had very little if anything to do with it other than to hear what was going on. To the extent that I was involved with that during my tenure as acting administrator, I honestly don't recall much about that.

One thing that's important that we did a lot on in HCFA, and it really started under Bill Roper, was work on effectiveness, on what works and what doesn't work in the practice of medicine. Ironically [laughs], one of the experts that caused us to think about this was none other than Don Berwick who had a colorful experience at CMS later on.

We were kind of cutting edge on the issue of effectiveness back in the mid to late '80s.

Berkowitz:

So let me ask you another question if I might.

I've been looking at people who have had your job either as the head of HCFA, or the head of CMS, or the acting head of those organizations. And I would say that the preponderance of them are Medicare experts; whatever else they are, they're Medicare experts. But you're not that way. You're someone who had deeper background on the Medicaid side than on the Medicare side.

Hays:

Well that's true. When I was with Social Security for about two years, if I remember right, '81 to '83, I was director of the Office of Hearings, or Appeals, or whatever that was called. But I think I had some other title, deputy associate commissioner. So I had some broader responsibilities in Social Security, but my only true involvement with Social Security was more on disability than on Medicare during that time. So yes, my experience was primarily with Medicaid and social welfare policy in general and not nearly that much on Medicare.

Berkowitz:

And SRS was working with Medicaid too, right?

Hays:

Right. There was a bureau of -- I forget the terminology exactly, but yes. SRS had AFDC, Medicaid, and some kind of a rehab services. The law required that there be a separate administrator for child support because Russell Long didn't trust SRS to do a good job on child support. So they created kind of a legal fiction that the director of the Office of Child Support Enforcement would be whoever the administrator of SRS was, and the day-to-day person would be the deputy director, which was me.

Berkowitz:

I see. So when Jimmy Carter created HCFA, one of the ideas -- I guess, a Califano idea -- was that Medicare and Medicaid should be united.

Hays:
Right.

Berkowitz:

But if you look at the history of the agency, it seems to me, and I could be wrong about this, that Medicare is the big dog, in a sense. It seems to dominate the agency's business. Is that true?

Hays:

Yes, I think that's true, at least in my time. There was a separate component of HCFA for Medicaid and it was not really integrated into HCFA, as I recall it.

Berkowitz:

Did you have any kind of special brief for Medicaid, or it was just another part of your agency's job?

Hays:

It was just another part. When you're processing however many million claims -- every day I would wake up, this was before the 24-hour news cycle, wondering whether there was a disaster involving the agency on the front page of the *Washington Post*. You know that virtually any Medicare claim has the potential for becoming a disaster. Fortunately, most days there wasn't such a story on the front page of the *Washington Post*.

I do think it's fair to say that Medicare got the lion's share of the time and attention.

Berkowitz:

Another thing that interests me about this particular agency is that the big leaders of the agency, the top leaders, the political leaders of the agency, are often working in Washington in the Office of the Secretary near the Congress. But the bulk of the agency works in Baltimore, that huge headquarters --

Hays:

I actually haven't been there; I've only seen pictures of the Taj Mahal.

Berkowitz:

Right. The fact that they got to build that is actually quite remarkable. But it's obviously a huge place. And so there are all these people in Baltimore doing day-to-day things. And there are a few people in Washington doing executive things. So how did you manage that? Were you mostly in Washington?

Hays:

Well I have no idea what it's like today. But my recollection is that I did spend a lot of time in my Washington office, but I also spent a lot of time in my Baltimore office, and some days I would be only in one place or the other, and many days I would be in both places. I don't know whether they still have a car and driver for the head of organization, but in those days they did and it was very helpful because I spent a lot of time going back and forth on the Parkway, so I'd use that hour or so to get work done. But I had to spend a fair amount of time in my Washington office because I had to spend a fair amount of time

either up on the Hill or helping to grease the skids of the bureaucratic process in the Office of the Secretary. And I had to spend a fair amount of time in Baltimore.

Now, again, at least in those days there was a small staff of people, probably the Congressional affairs people, who were physically located in Washington. And then a lot of the higher level people would frequently have to come because they'd have to be in the same meetings that I might have to be in with the Secretary or whatever. So it was both. I honestly don't remember anymore, whether it was 50-50, whether it was 75 percent D.C. and 25 percent Baltimore, but I was not -- believe me, I was not just in Washington.

Berkowitz:

So you've had a chance, a little bit of a chance, to observe this agency over time and to look and see different people trying to run it. I was curious about whether you think there's a kind of a person, or a skill set, or a personality that is really best suited to run an agency like CMS?

To put a point on that question, Bill Roper is often mentioned as a very effective administrator both at HCFA and also in other places in the government. Does that make a difference? Is there a bump when there's somebody like that that's perceived as competent or dynamic?

Hays:

Well, I think so. Now, you know, I think I only worked for two HCFA administrators, one being Bill Roper and one being Gail Wilensky. Well, I guess technically I worked for Bill Toby when he was acting director, or acting administrator, but I was his deputy. So I can only compare those two people.

Berkowitz:

Both of whom are quite dynamic figures.

Hays:

Yes. I think Bill was probably more highly respected in terms of being a healthcare professional. He was an M.D. himself. Gail Wilensky, PhD, was viewed as more of an academic, more of a politician. Bill Roper was more easy-going, more casual, more even-keeled. Gail Wilensky was maybe a bit more hot-tempered and volatile, so to speak.

But beyond that, I think the person's ability to deal with the bureaucracy is critical. This probably depends a lot on the administration and on the Secretary. I have no idea what it's like today, but I would have to say that in my day, a huge part of it was being the intermediary between the Secretary and the subordinate leadership and bureaucracy of HCFA.

And knowing how to work the system, because you've got to -- at least, again, in my day you had all those assistant secretaries that you had to deal with and you had to understand how to work the system, and how to get decisions made, and how to make that work smoothly, and how to explain it in words that people who were not healthcare professionals could understand -- although Lou Sullivan was in fact a healthcare professional. And for a

while, Doc Bowen was Secretary, if I'm remembering right; he was another health care professional.

Berkowitz:

And was called that, right? People called him Doc Bowen.

Hays:

Yes. I think being a subject matter expert is probably less important than knowing how to navigate the bureaucracy both above and below you, how to work with the Congress, which we haven't talked about really, but at least in my day, was hugely important, and very time-consuming, and ultimately extremely frustrating.

Other important skills are how to communicate, how to inspire, how to set a vision, how to get the organization behind you, and working with you and not working against you, and still have the trust and confidence of your political overseers. Everyone has one, even the Secretary, as Joe Califano discovered. Jimmy Carter got tired of seeing Joe Califano's picture on the front page of the *Washington Post* every day and it did him in.

Berkowitz:

[laughs] There's another similar story in Social Security. Lyndon Johnson looked at the newspaper one day, and Robert Ball's picture was on the front of *The New York Times* when Medicare was being implemented. And Johnson immediately called up Ball and said, "What office are you running for?"

Okay, now, we've talked about your time at HCFA but we have never talked about your time after that. And I was just wondering if I could just kind of at least get this straight about what you did after HCFA.

You were the acting administrator until about February, 1990. And then you came back, or you never left or how did that all work?

Hays:

Well, I stayed physically present at HCFA until about May or June of 1993. When Gail Wilensky was there (February 1990 to March 1992), I reverted to being associate administrator for operations again. Bill Toby became the acting administrator during 1992 (from April 1992 to May 1993). During the period that he was the acting administrator, I was his acting deputy administrator. Lou Sullivan was the Secretary.

Berkowitz:

Was that a problem for you to go from being the head of the agency to being the second-in-command?

Hays:

Well, I think the bigger issue is that, to be honest, it was very -- it was challenging to work for Gail Wilensky because she was very determined. She really wasn't all that interested in other people's opinions because she considered herself to be the expert. I felt her deputy, a guy by the name of Mike Hudson, probably took the brunt of that. And I think he

probably had an unhappy tenure as her deputy. But I knew that it was a temporary thing for me to be the acting administrator, and I knew that at some point they would find and confirm somebody to be the administrator and I would go back to my regular job.

Berkowitz:

So now, before we leave I wanted to ask you about your next career steps because it's such an interesting thing. You had this amazing career transformation from the Senior Executive Service to something completely different in a completely different field. I guess it's not so unusual, people have second careers after the federal service, but still this is quite a story. Could you talk about that just a little bit and how you disengaged from the federal service and engaged with religious service?

Hays:

Sure. In 1993 I was able to go to Johns Hopkins where I got an MPH from the School of Public Health. During that time I remained a federal employee. It was under some program that I had the opportunity to either go to the Kennedy School or to Hopkins and I chose to go to Hopkins, and get an MPH. When that was over, or as it was ending, I then ended up being able to negotiate an Intergovernmental Personnel Act position in which I ultimately went to UMBC, University of Maryland, Baltimore County. I was still technically a HCFA employee, when I helped to start something, at UMBC, called the Center for Health Policy and Development, CHPD, and was helping the Secretary of Health -- or whatever his title was -- for the state of Maryland. I did some work on Medicaid reform. We had a contract with the state Medicaid agency -- I forget what their official title was in Maryland -- and did that work.

And then finally in 1996, I took early retirement from the federal government. By that time, I had decided to pursue ordination in the Episcopal Church. So my federal employment ended sometime in mid-1996. I started Virginia Theological Seminary and graduated from there in 1999. I was ordained to the priesthood and continue to serve as an Episcopal priest, for about seven years in Connecticut and now seven years in Pittsburgh, Pennsylvania. During my seminary career, I continued my work at UMBC on a part-time basis to help pay the bills.

It's not unusual for people who are in mid-career to experience, or pursue, a potential call to ordination. And in fact, in my seminary class, I had two classmates who were both lawyers, as was I originally. And so it's not that unusual. There are a lot of what we call second career people in the Episcopal Church, and perhaps in other denominations as well. It was something that, for me, had started in the, oh, mid-80s as I got more and more involved in my local church in Maryland.

Berkowitz:

Was that Anne Arundel County or --

Hays:

Yes. In Severna Park, to be more specific, that's where I lived. And so I became more and more active in my church. Sometime in the early '90s, I'm not sure when exactly anymore, maybe around '92, '93, I entered a formal discernment process with the Episcopal Diocese of Maryland. As I went through that program, I made a decision that

yes; I really did feel as though I was called to be an Episcopal priest. And fortunately the community and the bishop agreed, and I was approved, and went on to seminary, and ultimately got ordained.

I've always felt as though I'd had an incredibly rewarding career with the federal government. I never complained about being in a job I didn't like. I had a whole bunch of different jobs, and they were all challenging, and rewarding, and exciting, and of course often frustrating and difficult. I don't think this truly influenced my decision to pursue ordination, but I felt there was really nothing left for me to do and by the time the Clinton administration came in, I had been working so long at the higher levels of Republican administrations that I pretty much had a bull's-eye on my forehead and I knew that if I stayed around, I'd probably be sitting in an empty office somewhere with not much to do. I really didn't want to do that, which was one reason why I was happy to go off and work for the state of Maryland and UMBC with the Intergovernmental Personnel Act assignment.

Berkowitz:

It's a remarkable story in lots of ways, but what I find the most remarkable about it is that you could go back to school like that, and go to the seminary. To go from being an agency head to being a student must have been quite a shift.

Hays:

[Laughs] Well, of course I had done that for virtually a year at Hopkins in '93, '94. So going back to school in '96, I had done it more recently. But when I started going to Hopkins it had been a long time since I'd graduated from law school in 1969.

Berkowitz:

Right, when you took biostatistics or whatever you had to take. Epidemiology.

Hays:

Oh my, yes. I had to reteach myself algebra.

Berkowitz:

But I guess you learned to cope with those kinds of things. So now I've got one last question for you, if I might.

Today as you are in Mt. Lebanon, Pennsylvania, which I believe is near Pittsburgh, I think?

Hays:

[affirmative] A suburb. Close, relatively close-in suburb of Pittsburgh, yes.

Berkowitz:

And you are in charge of your congregation and your church. Does health come up in this job of yours you have now? Are you, say, particularly health-conscious, or is there any carryover from what you were doing before to what you're doing now?

Hays:

Well, I think probably the biggest carryover comes in things like the budget, and numbers, and dealing with people. That has a bearing on what I do virtually every day. After you've

dealt with billion dollar budgets, dealing with an \$800,000 budget is sort of like a walk in the park.

In terms of the health part, maybe my current work is more around public health. I'm more concerned about the stress in people's lives and the health of their kids, and are people getting vaccinated or not, and are they anti-vaccine people. We have a parish nurse who takes people's blood pressure. And obviously, as in any congregation, we have some elderly people, and when I'm finished with this conversation I'm going to go visit a woman who is dying.

So -- it certainly helps me to understand some health issues and I spend, not a lot of time, but I do spend some time in hospitals. I think just knowing how the system works and being moderately familiar with Medicare and Medicaid is helpful. So yes, there is some connection for sure, but it's more the bigger issues than health, per se.

Berkowitz:

Right. I understand. I think that's a very good note on which to end. Thank you very, very much for doing this.

Hays:

Well, Ed, are we going to do this again in another ten years?

Berkowitz:

Well, there are a few assumptions there, but yes.

Hays:

You can call -- call me at the nursing home and --

Berkowitz:

[laughs] Right. Maybe I'll be in the same nursing home, you never know.

Hays:

[laughs] All right, well, it was a pleasure.

Berkowitz:

All right. Thank you again.

Hays:

Thank you.

Interview with J. Michael Hudson

Washington, DC on May 7, 2015
Interviewed by Edward Berkowitz

Transcript edited for clarity.

Berkowitz:

Today is Thursday, May 7th, and we are at the National Academy of Social Insurance headquarters in Washington, and I'm talking to J. Michael Hudson. You seem to be referred to often as J. Michael Hudson, can you tell us what the J. stands for?

Hudson:

It stands for John. That's my full name -- John Michael Hudson. But all during the public service I've been involved in, it was simpler just to say J. Michael, so people wouldn't call me John. I just go by Mike.

Berkowitz:

I see.

I want to talk to you a little bit about your life and about your service with what is now the Centers for Medicare and Medicaid Services. I know a bit about you, but maybe you could tell me a little more. I know that you were born in Hollis, Oklahoma in 1948.

Hudson:

Correct.

Berkowitz:

I noticed that at your confirmation hearing Russell Long made the point that he was going to confirm you, but that your birth date was the same as his entry date into the Senate. I think he was retiring at the time.

Hudson:

Yes, that Senate confirmation hearing was when I was at Treasury. I was fortunate enough to have Lloyd Bentsen nominate me and Russell Long was the presiding officer of the committee. It was interesting, short, and they were complimentary. I knew Senator Bentsen pretty well, but didn't know Senator Long at all. I was quite in awe of him and what he had to say. It was an interesting time. That was during the 1985-86 period when tax reform in the Treasury was moving forward, and Capitol Hill was taking it up.

Berkowitz:

I see. So you were born in Hollis, Oklahoma -- which is right near the Texas border?

Hudson:

It's a one-light town, east of the Texas border, north of the Texas border. I grew up in Amarillo, Texas, although I was born in Hollis. The claim to fame for Hollis was that it was the home and birthplace of Darrell Royal. And my mother actually went to high school with Darrell Royal and several of the coaches that were at the University of Texas were also from Darrell Royal's hometown.

Berkowitz:

We were talking here at NASI about that, and reaction among some was "who is Darrell Royal?" I just couldn't believe everyone didn't know that.

Hudson:

You'd have to know Texas Longhorn football. People from the East Coast generally have their own teams, but in the South and Southwest -- the University of Texas has had a long tradition, along with the University of Oklahoma, as an intense rivalry. It plays itself out -- it's called "The Red River Shootout" in October of every year.

Darrell Royal was the coach for many, many years, and led them to a National Championship several times. It still is a rivalry. The stadium is named after him in Austin -- he is an icon in Texas football and it is the sport there. Basketball is great, lacrosse is up and coming, baseball is good, but there's no other sport in Texas that garners as much -- you wouldn't call it patriotism -- but garners as much spirit as Texas football.

Berkowitz:

You moved at some point from that town in Oklahoma, to Amarillo, Texas?

Hudson:

Yes, my father was a Kraft food salesman. He was a truck driver and delivered cheese to stores in and around the Tri-State area, which is New Mexico, and Texas and Oklahoma.

This is in the late 40s, early 50s when he came back from the war. He was transferred to Amarillo and I grew up and went to the public schools in Amarillo and then went to college for a year at the college in Amarillo, and then transferred to the University of Texas. I don't even remember what year it was -- early 70s.

Berkowitz:

Did you work a little bit before you went to that first college which might be called a junior college?

Hudson:

I did. My father and I had a special arrangement about how my schooling was going to be financed. He told me this, "You go to work, whatever amount of money you can make in the summer months, I'll match." And that turned out to be an advantage for him initially. But after that first year at Amarillo College, I was fortunate enough to get a job on the Red Ball Motor Freight Company in Amarillo which was a union company. I had to join the union, and I made over \$5 an hour. That was a huge amount of money for someone in college at that time.

When I presented the bill of lading to my father at the end of the first summer there, and he had to match it, he was aghast that he had to pay so much [laughs]. But it certainly paid for everything, and for two successive summers.

Austin was -- for in-state tuition -- very inexpensive. For out of state tuition even then, it was highly expensive; it matched what Catholic University and Georgetown and George Washington charged here at the time for out of state tuition -- pretty expensive. But the money that I made and that my father matched put me through school for three years in Austin. I lived nicely.

Berkowitz:

I see. So you went directly from the Amarillo College to the University of Texas at Austin and then graduated in 1972, and that's during the end of the beginning of the Vietnam War. At some point, you seem to have come up to Washington to work. How did that come about?

Hudson:

Yes, interesting story there. My mother's relatives were involved in the Manhattan Project. They were both physicists. Two of my mother's uncles were physicists and were involved in the Manhattan Project. And the third uncle was involved in the precursor agency of the CIA. He was an agent at the Office of Strategic Services.

There was a fascination in our family, on my mother's side of the family, with all of the people who were somehow affiliated in Washington in some capacity. So, when I graduated or when I was about to graduate, it was pretty clear that I was going to come up here and work for a while and then try to go to graduate school -- which is exactly what happened.

Berkowitz:

What was your mother's maiden name?

Hudson:

Hammonds.

Berkowitz:

It's an interesting conjunction of the Manhattan Project and Hollis, Oklahoma.

Hudson:

It's very, interesting. We are Native American on my mother's side, -- they are Native American. Hammonds is a Native American name. So I'm one thirty-second Native American. At least one thirty-second, maybe more.

Berkowitz:

So, you came to Washington right after graduating from Texas and if I understand it correctly, you got a job with the Congressional Research Service?

Hudson:

Yes.

Berkowitz:

I think of that as a very hard job -- requiring a lot of writing and that sort of thing. Is that what you did?

Hudson:

Well mine was an entry level position, and largely involved gathering data, articles and forwarding it to staffers on Capitol Hill who wanted to build a library of sorts on any one issue. They didn't rely on us to analyze much for them; they wanted us to collect the data and they would take it and do what they wanted to do with it. That was fine with me; it gave me a very, very good appreciation of how to use an immense resource like the Library of Congress for any kind of work you want to do. CRS was an exceptional training ground in understanding the legislative process, understanding how Congress works, understanding what they take into account when they write legislation. And CRS then and I'm pretty sure today is held in pretty high regard for the kind of work that it does.

Berkowitz:

And giving a straight story; they're famous for that too -- without any kind of political overlay.

Hudson:

Their charge is quite clear there: they are not to interpret or make their own judgments about anything in law. They're to give a complete analytic point of view -- here's one side, here's another side, here's what the law says, and they're impressive. They have done an exceptional job, and most of the friends that I came here with also worked in CRS. We all got a pretty good indoctrination; it was almost an introduction to graduate school, which is what I then next did.

Berkowitz:

Were they doing issue briefs?

Hudson:

I didn't do them, but the material we would put together would be given to higher or senior level individuals; they'd take a look at the material and they would do an analysis of it, and hand it on to the people who actually vetted it before it went to a member of Congress or a Congressional committee. It was pretty thorough.

Berkowitz:

You came in just about the time of transition into a much larger staff presence in the Capitol. But there was a time when the Library of Congress -- or the CRS -- those people actually conducted hearings. Was that the case when you got there?

Hudson:

I know what you are talking about. Things changed dramatically when they passed the Legislative Reorganization Act. That turned things around entirely, and put a reform in

place about how Congress actually did its own business. That was when I began to understand a little bit more about how Congress should function and how it was different than what it had been doing.

Berkowitz:

Right, and the one area that I know is Social Security, and I know that the Committee on Finance relied heavily on these people from CRS to help them because they actually didn't have a specialist on that subject.

Hudson:

They didn't have the expertise to really put together analysis of that sort. They developed that over time. Walter Oleszek, as I recall, was one of the individuals at CRS who was continually called upon for his expertise. I think he was in the American government division, but he would be called upon for all kinds of analysis and answers to questions about Social Security and how it should work, about how Medicaid and Medicare were supposed to work.

Until Congress developed its ability to analyze these things on its own, I think they were working in the dark. I don't know how committees' staffs ever put legislation together without the help of CRS.

Berkowitz:

They had to depend, I would imagine, much more heavily on OMB and also on the Executive departments. And with some committees also, the members of the Executive departments sat in on markups, and really played an active role.

Hudson:

Yes. My impression of that period was that the knowledge base and the power really resided in the Executive Branch. Legislative powers were limited to passing bills that they largely developed with the help of the Executive departments and agencies. And they took what they were told and sort of got a second view of it from CRS, and if things seemed okay, then they would attempt to put legislation together to do what they wanted it to do. But until the Legislative Reorganization Act passed, and Congress began doing its own budgeting, and understanding what it wanted to do, it didn't push the Executive Branch off to one side, but it certainly had its own ability to analyze what it wanted to do without -- they took advice from the Executive Branch and the departments -- but it was largely their own show at that point.

Berkowitz:

Right.

Hudson:

A strong, powerful chairman like Russell Long actually understood what the power was if they used it the way it should be used in their mind.

Berkowitz:

Were you working pretty much to stay in the library at this time? Were you forming bonds with any staff people or coworkers?

Hudson:

Oh no. I had one goal and one goal only, and that was to get myself into graduate school and somehow get it paid for [laughs].

So, fortunately for me, I went to summer school at AU and took a couple of classes. I took these classes before I ever actually applied to the full graduate school program. I went a circuitous route to get where I wanted to go. My acceptance into graduate school was in the communications program, but it was widely understood that when you are in that program, you can take as many classes outside the School of Communications as you wanted, so I took advantage of that. So my graduate degree is in Communications, but half of the curriculum was graduate government courses.

Berkowitz:

I see, so would you say you had a specialty in an area of policy at the time, or not?

Hudson:

Probably not. But it was a pretty liberal program, in the sense that it was wide-ranging. I had a chance to do all kinds of things in the graduate school. And AU had a very good program in graduate school for public policy. Still do.

Berkowitz:

So, as I understand it, you got a job -- a Washington job, as a lobbyist for the National Society of Professional Engineers.

Hudson:

Yeah.

Berkowitz:

And that doesn't seem to have too much connection to anything else, but you did that for a while.

Hudson:

It had nothing to do with anything, actually. I finished graduate school, I played for the summer -- I was still a kid [laughs]. I wanted to absorb the fact that I had just graduated from school, and this offer came along, and in my case, the way it worked in the Library of Congress, you really didn't have to pay back the program for any of the tuition that they granted you. Initially, it was set up in such a way that for every semester hour the CRS paid for, you worked a number of hours to pay back the program. By the time I graduated, they didn't formalize that, so I had no obligations really to the Library once I finished graduate school. They only wanted to make sure I graduated, and I did. So I'm not even sure how the offer came along; it seemed interesting. The individual who was running the organization at the time was involved in everything related to science -- it was not just engineering, it was science, and all related programs, education programs and science. It was an interesting offer, and it paid me double what I was making, and that wasn't much. It wasn't a lot of money, but it was double what I was making, and I was trying to pay back

a few bills and get myself on a sound footing and that's the reason I took the job. It didn't turn out to be as interesting as I thought it might be, so I moved on.

Berkowitz:

Then, as I understand it, you got onto more of a policy and political track. You worked for Senator Tower from Texas between 1977 and 1979. He is known, among other things, for being both short and conservative. How did your job with him come about?

Hudson:

Well, actually I was fortunate. I thought that I wanted to work on Capitol Hill to get experience, though I wasn't sure where that would take me. But it certainly seemed something that would be different and interesting.

I sent a resume to several congressional offices, just a scatter shot. I had no inkling that there would be any response. I didn't have any special talent, other than I had a graduate degree, and I was supposed to be a writer. I got a job offer both from John Tower and from Gillis Long, who was the member of Congress from New Orleans at the time.

I mulled the decision over for about three weeks, and I talked to everybody I could talk to. Most of my friends of course are Texans, and they said well, you'd be an idiot not to take this job. Win, lose, or draw, you would've been in the United States Senate. I thought about that, and I wasn't sure I was persuaded by that argument, but I did go see Tower and his people -- his legislative assistants and his administrative assistants, were really good. They were all women -- despite the fact that John Tower was -- and Republicans were known as hiring only men -- John Tower's top political people were all women in 1976.

Berkowitz:

Interesting. Because I think of him as interested in military defense kinds of affairs and you don't associate that with women, either.

Hudson:

You don't, and John Tower was on the Banking Committee, he was on the Budget Committee, and he was on the Senate Armed Services Committee. In 1980 he became the Chair. The reason I was hired is that they wanted someone to travel with Senator Tower -- he was gearing up for his re-election in 1978. I'd have to agree to take time away from official Senate business and travel with the campaign.

That was all pretty exciting to me. I jumped at the chance: it was a hell of a ride for a period of a year and a half; he had a really hard re-election effort. He was challenged by Congressman Krueger from San Antonio. Bob Krueger. John Tower, for all his abilities, was not well thought of by his own party in the state. He was not conservative enough, really, for most of the people. And he hadn't done his homework; he hadn't spent a lot of time in the state. There are all kinds of reasons why politicians don't get elected, he made all those mistakes. But on the plus side, he was a hell of a campaigner. He was a great campaigner, and once you heard what he had to say -- the people of Texas, they completely agreed with his philosophy.

He won that election by four tenths of 1% of the vote out of 4 million cast. And the results weren't known until about three days later.

Berkowitz:

Interesting.

There's a story that when Richard Kleberg -- a Texas congressman -- came into Washington, Lyndon Johnson was with him as his aide, and they stayed in the Mayflower Hotel for a night. It was probably the only time that Johnson stayed in the Mayflower Hotel for a very long time after.

Hudson:

[laughs]

Berkowitz:

Was Tower kind of a fancy traveler, a comfortable traveler?

Hudson:

He was professorial, he was a professor. He spent time at the London School of Economics, so when he came back and dressed like someone out of the London School of Economics and went to small, rural Texas towns, he wasn't well received.

[laughter]

And -- I'm being facetious here, but there was a side of John Tower that wouldn't let him let his hair down.

He was professorial; he was an academic, in the truest sense of the word. So when he'd go back to Texas -- in a way he had to change his personality. He could go from being completely urbane to South Texas smooth. And he had all these Texas expressions that were hilarious, that he could pull out of his hip pocket on demand. And it worked.

He won by the slimmest of margins, and I think it changed his attitude about the way politics in Texas was going to be going forward. It's just about that time that politics in the state of Texas changed. Texas elected its first Republican governor since Reconstruction. Tower was elected in '78 at the same time as Bill Clements.

The state was becoming more conservative. They wanted politicians to reflect not a Washington attitude, but a Texas attitude. So you had people like Bill Clements, who was an oil guy with very little experience in public service. His top aide was Karl Rove. Karl Rove and I dragged bags around little "po-dunk" airports all over Texas during that campaign. We'd come in on small planes, and they'd have to buzz the runway to get the cows off.

Berkowitz:

[laughs]

Hudson:

It happened more than once, I kid you not. And every time we'd see another jet over on the other side of the rampart, it would be Bill Clements and Karl Rove, carrying bags like everyone else at the time.

Berkowitz:

One thing that caught my attention, in looking at your resume; it lists you as a legislative assistant and also a press secretary for John Tower. Were you really a press secretary?

Hudson:

I was the traveling press aide. That was really my function. I was to work with the press that would follow us around; I had to write his remarks. He never used my remarks -- he was an eloquent speaker off the cuff, but those remarks would become something that could be given to the local radio stations and TV stations. That's how it worked. Small newspapers down there who are not dailies, but weekly newspapers; they relied on copy from politicians, and that was my job to get them copy and paper.

Berkowitz:

So you would call them up when you arrived in town?

Hudson:

Actually I didn't do that, he had a press operation in Dallas that mostly would inform the local affiliates and radio stations about whatever, his speech on Friday night. My job was to make sure when we got there that the press got what they needed, that we had the materials for them. We were to make John Tower available for questions and answers -- which he preferred to avoid.

It worked then as it works now. Press aides are there to serve as a bridge between the politician and the local media. They are quite important. I mean people in south Texas don't wake up mornings and read the *Dallas Morning News* with their morning coffee. They have the local, weekly newspaper which is their bread and butter. So they get everything that they want to know and need to know and desire to know from their local newspaper and their radio station. Radio stations were key to lots of communities where TV was not -- in that period -- the penetration wasn't very deep into the roots of south Texas.

The farm and ranch report is about all they wanted to know. So if we had a chance to get John Tower on the radio that was my job.

I think I failed miserably most of the time [laughs].

Berkowitz:

Well, he won the election.

Hudson:

Yes.

Berkowitz:

So, your next job was with Congressman Tom Loeffler who was also from Texas, right?

Hudson:

Tom Loeffler was actually John Tower's legislative assistant.

Berkowitz:

I see. But he was a Congressman, not a Senator. So you went from working in the Senate to working in the House of Representatives?

Hudson:

Right. The reason that occurred after the election -- everybody changes jobs and moves on after elections like that. There wasn't much for me to do. Tom Loeffler in that same year was elected to this House seat essentially from Hunt, Texas. The district is between Austin and San Antonio. It's the so-called hill country of Texas.

They were looking for a press aide, and Tom needed somebody with Texas experience, the campaign experience I'd had. He had worked in the Ford White House; he was the top House liaison in the Ford White House. His administrative assistant was the individual who -- in the Ford White House -- ran the Senate and House liaison from OMB. Alan Kranowitz was his name.

There was a strong connection between people who worked for John Tower and people who went on into the Ford White House and then people who went on in politics and did other things. Dick Cheney, at one point, was on that staff, in the Nixon White House, and had a role in the Ford White House obviously as Secretary of Defense. When Ford lost, all of those individuals went on to do various and sundry things.

Donald Rumsfeld went on obviously and did other things. But Tom Loeffler was the new House member, freshman House member from the 23rd Congressional District. So I joined his staff and worked there for about two-and-a-half years.

Berkowitz:

Was Mr. (Jake) Pickle in the House at that time?

Hudson:

Yes, he was.

Berkowitz:

They must have been contiguous, those districts?

Hudson:

Yes they are. Jake Pickle -- nicest man in the world.

Berkowitz:

And I think his district included the city of Austin, right?

Hudson:

Yes, it did. That was the LBJ seat. When LBJ was a House member, that was his seat. Jack Pickle was the nicest gentleman I've ever met -- he just couldn't have been friendlier

and nicer. He had the same personality, the same “go-gettedness” as LBJ. I didn’t know LBJ, but if you’ve read the books on LBJ, then you’ll know he was aggressive and went after everything. And Jake Pickle, one of his aides at one time, was exactly the same way. Nicest man in the world.

Berkowitz:

Interesting. Because of course LBJ just ate those people alive.

Hudson:

Ate them alive. He tried that with Lloyd Bentsen and it didn’t work. But Jake Pickle, he was a true, loyal friend of LBJ’s.

Berkowitz:

I know that you were in and around The White House, during the Reagan era. You were over at OMB for the first term?

Hudson:

Right.

Berkowitz:

And then in The White House itself -- it looks like a Special Assistant to the President between 1984 and 1986, and then Deputy Assistant Secretary of the Treasury?

Hudson:

Assistant Secretary. Well it’s a long, convoluted story. I’ll try to make it concise and short. Alan Kranowitz, who I mentioned, was the liaison from OMB to the Congress in the Ford White House. He was the administrative assistant to Tom Loeffler. When David Stockman was appointed OMB Director, he was looking for someone with both House and Senate experience to do the work that he needed done on Capitol Hill.

I knew going into the job that my predecessor in that job working for Dave Stockman lasted all of one week. I’m not sure I know the reasons why, but he didn’t last in the job very long. I knew this going in, so when I was offered the position, I had some trepidation. At that time -- and granted, this was a new era, but at that time, Phil Graham and David Stockman knew more about the Federal budget than anybody in the Congress. And talk about somebody running over people, Stockman and Graham did that.

I was fortunate enough to work for him (Stockman) for three years. He and I got along famously. It was a learning experience because he was the most demanding boss I’d ever had up to that point, and the one individual you wouldn’t want to go into his office and say “gee, I don’t know the answer to that question.” He’d say “what’s going on here?” and you wouldn’t want to say “I don’t really know the answer to that question.”

Berkowitz:

He was a member from Michigan?

Hudson:

Yes, he was a member from Michigan. He wasn't a good politician, but he was elected, and he spent his working days and nights doing nothing but budgeting. I've never seen anybody work at a frenetic pace like that. Literally, he worked seven days a week.

Berkowitz:

Did you get the sense that he thought he was a lot smarter than Ronald Reagan?

Hudson:

No, I don't think that was it. He immediately got into the job and realized the budget was not going to be as easy to solve as he thought it was going to be.

We were in a deep hole, deeper than anybody thought. The Federal Reserve and the President decided they were going to turn that around. And when they did that, when they clamped down on rates, and the economy went into the tank, of course revenues fell off, and then things really did look bad.

I think it wasn't so much that Dave overestimated his own abilities, as he underestimated the depth of the problem. It was a serious problem. It obviously was very controversial what President Reagan was attempting to do. No one thought that it would work, and Stockman got in a lot of trouble early in my tenure there and, early in his tenure there by having a long on-the-record conversation with Bill Greider, which came out in The Washington Post and just about sank the President, and it certainly just about sank Dave Stockman.

Berkowitz:

Did he think of Medicare and Social Security as the enemies in terms of creating budget problems? David Stockman said of Social Security that it was "the fortress of the welfare state."

Hudson:

I wouldn't say he made light of it, but his job was to try to deal with the discretionary side of the budget as best he could. Entitlements were a whole different kettle of fish, and other players were involved in that, including the Secretary at HHS and people who had a different view of how to reform and change and turn those programs around.

In any administration you're going to run into conflicts between Secretaries, between cabinet officers, and internal conflicts were quite clear. Then you had an interesting relationship that evolved between Bob Dole and Dave Stockman.

Dole had jurisdiction over Medicare and Medicaid and Social Security, but he also had jurisdiction over taxes; and the goal then was to lower taxes. If you're going to balance the budget and you can't do anything about entitlements, and you're going to lower taxes, how does that math actually work? And, therefore, you can see the dilemma that Dave Stockman was confronting. Entitlements on a roll-up, defense spending on a roll-up, and the President and his administration were insistent that taxes needed to be brought down. Pretty hard set of things to juggle and come up with solutions for.

Berkowitz:

Senator Dole, just to get this straight, he was head of the Finance Committee. At his point he was the Chair because the Republicans had won that election.

Hudson:

Correct. This is 1980.

Berkowitz:

So, now you went over to Treasury at some point.

Hudson:

Yes. Before that, the person who hired me was Max Friedersdorf. Max ran President Reagan's Office of Legislative Liaison so I actually reported to Max. My immediate boss was Dave Stockman, but in my role I really had to coordinate through and with Max Friedersdorf -- a superb individual.

Berkowitz:

Is he from California?

Hudson:

I don't know where Max is from. I think he's actually from Illinois or Indiana. He was hired by a Congressman -- I think it was in the earlier part of the Nixon years. I've lost track of when he actually came to Washington, but he was a reporter who came here, worked for a congressman, and then went to work, I believe, on the Nixon re-election campaign. But he actually was hired by Donald Rumsfeld and Dick Cheney at the Office of Economic Opportunity. Rumsfeld was asked by Nixon to head up the OEO, and he did that. He brought Dick Cheney along with him, and they hired Max Friedersdorf to run their office of liaison to Capitol Hill. That whole connection to the Rumsfeld-Cheney crowd began with my experience with Max Friedersdorf.

Berkowitz:

So, you were with David Stockman and then you were Special Assistant to the President, which is a different job, right?

Hudson:

It was a different job, different responsibility, different reporting assignments, but it was essentially interacting with members of Congress, both sides, Republican and Democrat, on issues important to Reagan.

My areas of responsibility included budget. When I moved from OMB to the White House, my areas switched from not just the budget, but to environmental issues, energy, policy, and taxes. So, that's the way at that time the Office of Legislative Affairs was divided up. Four of us had responsibilities for those committees of jurisdiction and those members on that certain committee, House and Senate. It was an interesting way to get to know members of Congress when they were behind closed doors.

Berkowitz:

Did you have any heroes from that experience of whom it could be said: "that's a very good congressman," "that's a very good senator"?

Hudson:

Heroes? I wouldn't call them heroes. I don't mean that cynically. I got to know many members, many Senators directly in pretty intimate sessions like in my time at OMB and the White House. The most interesting individual, I would say, in my opinion would have been Mark O. Hatfield from Oregon who was the Chair of the Senate Appropriations Committee for the entire time that I was in the White House and the OMB.

He was a tough guy, a really tough guy. There was a lot of banging of hands on the table in my presence and a lot of punching of the index finger in my chest. That's goes with the job.

Mark O. Hatfield was good man and a good legislator, and he had a point of view. The term "liaison" really means something important here because he and Dave Stockman did not get along at all. They were constantly clashing, and it's because of the policy, not for reasons of personality, but because of what Stockman was trying to do and what Mark O. Hatfield opposed. He thought changes and budgeting needed to also focus on the entitlement programs. His responsibility as Chairman of Appropriations was on the discretionary side, so he wanted more emphasis by the White House on reforming the entitlements. It was always the constant debate.

Berkowitz:

I see. So, then the Treasury job came out of that?

Hudson:

Well, the individual who had the job, Bruce Thompson, I knew quite well. When he left in 1985, Secretary Baker asked him who should get the job, whom he would recommend. Fortunately I'm the only one he recommended, and I was the only one they considered. So, I went to work for James Baker and Richard Darmon. Darmon was the day-to-day decision maker. Jim Baker was Secretary, flying at 30,000 feet on all issues, internationally and domestically.

Berkowitz:

Darmon was supposed to be smart.

Hudson:

Darmon was a very smart guy, and his unfortunate personality was that he made sure everybody knew he was the smartest person in the room. And that's not the way it actually needed to work to get anything done on Capitol Hill. As the liaison, I was the person in between a lot of that conflict. Where I found good working relationships were with the staff of Ways and Means – the Democratic staff of Ways and Means. Dan Rostenkowski – a superb legislator, and his people on Ways and Means -- all tax lawyers, were excellent to work with.

Berkowitz:

Interesting. James Baker I think of as a George Bush, Sr. guy, at least at first. Was that a connection too? I know Bush 41 was a Congressman from around Houston.

Hudson:

I didn't know the Secretary well; I didn't actually know him very well at all. He was the Chief of Staff to President Reagan, and we had occasional interactions with him, but not many. When he became Treasury Secretary, he had more of an ability to focus on things, discreet things within his portfolio. He's very, very good at it. Fortunately for me, I had a good working relationship with him. I knew his son very well and I knew a lot of people around him from Texas, and most of his friends were in the Texas oil business. Some of them I knew fairly well, and so it gave us a pretty good working relationship all the way around.

The tax reform was a very difficult period of time for two years or so, and we struggled to get a bill passed the President could sign, but we did it.

Berkowitz:

When Baker went to Treasury, there was a famous job swap, as I recall. He actually swapped jobs with the Secretary of the Treasury, Don Regan. Were you in on that?

Hudson:

Well, I knew all the people around both men, but I didn't know exactly why it occurred. My impression was Secretary Baker -- Jim Baker -- wanted some authority over a department or an agency. He'd already been a Chief of Staff -- he was essentially Chief of Staff for Gerald Ford, and he didn't want to do that anymore. He wanted something at an operational level, and after four years in the White House as Chief of Staff, he was ready to move on.

Don Regan actually wanted to do exactly the job that Baker had. He wanted to be in charge and manage a White House staff. Why he'd want to do that is beyond me, but that's what I was told and what I recall of that swap.

Berkowitz:

And Reagan said fine?

Hudson:

Well, he liked them both. He and Don Regan were very close. Old Irish guys, you know; they liked to have a drink at the end of the day and chit chat about business. They were really compatible, I think. And, Don Regan had managed a big Wall Street firm, and so I think the expectation was that his managerial ability would be good, and his business sense would be good, and his business acumen and relationships would be good. What he was not good at, just in my opinion, was the relationship building required to do what he was doing with other individuals in the government, people on Capitol Hill.

The Chief of Staff's job really is, as much as anything else, making sure Capitol Hill and the President are singing the same tune, and if there are hiccups along the way, Chief of Staff has to manage that for the President, any President. But, Don Regan was not as good at that as he was at many other things. Jim Baker, on the other hand, was pretty good at the back-slapping required and very good at the detail of getting something accomplished and was one of the most effective individuals I've ever been around.

Berkowitz:

I see. So, we've come to the end of the Reagan administration, succeeded by his Vice President, and you went to work as Deputy Administrator at HCFA in 1990 under President Bush. Can you tell us a little bit about that, how that came about?

Hudson:

Yes. There was about a two-year interregnum there when I'd gone out to work for Tom Loeffler, who had resigned to run for office as governor. He was not elected Governor of Texas. He started his own law firm and I went to work for him briefly.

What I wanted to do, which I'd never been able to do when I was in the White House or at OMB, was to understand something about how entitlements actually could get reformed.

I believe it was about two years into the Bush White House; they didn't have an administrator for HCFA. Drew Altman was the individual who was trying to get confirmed. I understand that John Sununu who was Bush's Chief of Staff, told him, "You go up and get the confirmation votes for yourself, and we'll nominate you."

In the meantime, nobody was running HCFA, nobody was in charge. A group of individuals who were there -- associate level folks -- and a secretary were running the section on Medicare and Medicaid. So my name surfaced as a potential candidate for the Deputy's job from Professor John Cogan. John Cogan was a scholar at the Hoover Institute at Stanford...

He and I were associates and good friends from OMB days. He was an Associate Director at OMB when I was there. He teaches economics at Stanford. He recommended me to the people in the White House and he recommended me to Gail (Wilensky), who ultimately became the candidate for the job.

I was preparing to move over, but it didn't make a lot of sense to me to go over and become a deputy to somebody if we didn't know each other and we didn't agree on how to manage an agency. It wouldn't make a lot of sense.

Gail Wilensky called me. She was going to be nominated, and she said, "Gee, John Cogan's talking about you. I don't know you. Let's get together and see if we can make something work out of this." I think we spent three hours together, and became steadfast colleagues and in my opinion she had exactly the right ideas of the things that she wanted to do.

I brought a set of skill sets to the table she didn't have. I certainly wanted to learn from her, given her academic background and her health economics intuition and what she thought would be important to do while she was the Administrator. I think we made a pretty good team. I was to keep her out of trouble on Capitol Hill. I was to sort of manage the internal legislative operations and work within the office to make sure things got done on time. Out of the arrangement I got a set of managerial skills that I hadn't had before; I got a chance to work with her, got a chance to work with reforming a lot of the things we set out to reform; most importantly in my mind, Medicaid. At that point there was a huge problem with how Medicaid was being financed at the state level. We spent a year on that.

Berkowitz:

The states were getting these matches that were favorable to them. Was that the problem?

Hudson:

Well, the federal government's point of view was that the states were inappropriately using and gaming the federal match. And, there are, of course, different ways to think about how it should work; but when I got there, almost within a period of six or nine months, we had a huge problem with this outflow of federal dollars into state coffers that GAO and everybody else were saying was inappropriate given what was intended by the federal/state partnership. So, my friend Tom Scully and I and Gail worked very closely during this period of time.

My friend Tom Scully said, "You know what? I think we have to solve this problem." He sold Secretary Sullivan on the idea that there should be a Medicaid SWAT team. I discovered that I was the head of Medicaid SWAT team by reading it in a press release. If you know Tom Scully, you know how Tom Scully is.

I say that laughingly. Tom's a very good friend of mine, but he sometimes made decisions like that which lots of us found out about later. He did a very good job at OMB. He ran that office over there, and he was responsible for all of these things to Richard Darmon.

It was an intense period of time, but there needed to be some resolution to what was going on from the perspective of the federal government.

Berkowitz:

You said, "My friend Tom Scully." That's because you knew him from where?

Hudson:

I knew him when he first went to OMB. He had the job I had, the Legislative Liaison job. We got to know each other over time, and when I was appointed to Deputy, then we had some good meetings and lots of friends that we both knew. It became a pretty good working relationship.

Tom's a pretty open guy, easygoing guy, but pretty determined to do what he wants to do. And, he worked for the most determined OMB director I'd come across. You may recall there was something called the negotiations over the budget at Andrews Air Force Base in 1990 -- I don't even remember the time now, but it was so partisan and acrimonious that they had to take the negotiations over the budget to Andrews Air Force Base where they hoped that no one was going to leak material to the press about what was being discussed, because both sides had a stake in the game and didn't want leaks.

My long and short analysis of what happened at that period of time was that Darmon managed to save about \$48 billion dollars of entitlement budget savings out of that negotiation. The actuaries concluded that in that very same period of time, \$48 billion dollars, or thereabouts, inappropriately went out to the states through the use of these

gaming arrangements. I say that pejoratively in the sense of the federal government's point of view which was that the gaming arrangements should not have been happening.

It didn't violate the law but was not the way the Medicaid cost sharing was supposed to be. It all was distorted by so called "provider taxes" and the like.

It was found that for every dollar Darmon saved through these intense budget negotiations, he had lost as much on the Medicaid side through these gaming arrangements. He was furious. And, you can't blame him. All that work and he was right back at square one in terms of making progress on the budget deficit. He encouraged, and President Bush went along with, taxes, as a part of that negotiation. So, he agreed to taxes and it cost him his job.

Berkowitz:

I see. You described your relationship with Gail Wilensky. Is it fair to characterize it as Gail would say "I know about the program, this is the kind of stuff I want to do, and I need to talk to Senator so-and-so," and then she would ask you how to do that? Is that the kind of relationship it was?

Hudson:

Well, the way it worked initially was I wanted to make sure I understood what Gail's thinking was on everything so I could be helpful. She wanted me in the room so if she said something to the staff or said something to a member of Congress that would be the wrong thing to say, I would be there to provide counsel and advise her about what to do. So, what turned out to be a mutually beneficial working arrangement was that we literally did everything together. Now, that's not the best management style, for sure, but every meeting she had, I would be in the meeting; every meeting I would have, she would try to be part of it.

It really became important when we got into these very intense negotiations with the National Governors Association. These so-called provider donations and tax arrangements needed to be fixed and needed to be reformed. The executive branch's point of view was, "You guys over in HFCA are in charge of this. You and the Secretary go get it done!" So, we engaged in discussions with the National Governors Association because they were obviously the point person for all of these governors who were utilizing this set of arrangements.

If we were going to reform it, we needed Congressional approval; we had to have concurrence on the part of enough members of Congress to get something passed in the form of regulations. It was very complex, very intense. In more than one meeting I attended there were members of Congress from states who were using these arrangements to pay for Medicaid and other things. More than enough members of Congress were pretty upset about what we were trying to do. It was very controversial.

Berkowitz:

I see. Did Gail take direction well from you?

Hudson:

Direction -- well, I wouldn't say that. I wouldn't call it direction. I would offer commentary -- Gail would take it or not take it, and that's her prerogative, and my job is to help her if there's an area where we are involved and engaged in discussions. If I had a point of view, I'd give it to her. She would take it or not take it, but by and large, the relationship developed in such a way that we could think together. We'd come to a conclusion based on a discussion, and it got to the point where we were finishing each other's sentences almost. It was a very good working relationship. She and I are very close, and she's a good friend.

I think she did an exceptional job. I don't mean this in a sense that we got there and we reformed it; what I mean was HCFA was considered by most everybody in Washington as sort of a backwater agency, even though it was in charge of Medicare and Medicaid. It hadn't done much. Len Schaffer came in and essentially created HCFA, but then he left and nobody was really in charge after that.

So what I thought was possible -- and I think Gail agreed -- was not only should HCFA be more in charge of how these programs should be administered, it ought to have a role and say in how Congress determines what to do in entitlement programs. That was her view, and I think she was absolutely right.

I don't know what she told you about that, but I think that she made a difference and I was happy to be there as a part of it. I learned a lot.

Berkowitz:

Speaking of learning, how does one come into HCFA from the outside and get up to speed on Medicare and Medicaid?

Hudson:

In my job in HCFA one of the offices that I oversaw was the Office of Legislation and Policy, OLP. Those people were the best people and most knowledgeable individuals about these programmatic details that I'd come across. Most of them, for good reason, made sure they were not political. They didn't want to be political, but if you asked them to do something, they would do it, and they would give you exactly what you wanted. And so, there was an ability to say to the professional staff in HCFA -- I need to know how this program works. Give me the succinct version and tell me where the problem is now. That, of course, could not occur on donations and taxes. Nobody in the federal government had any idea what the states were doing with these programs. Each individual state was running a different gaming operation. They were different in each state, and my job as the head of the SWAT team was to go in and analyze and compile what was being done, and then Gail figured out what we were supposed to do about it.

Berkowitz:

You were the Acting Administrator in March and April of 1992. How did that work out? It was following Gail's departure.

Hudson:

Gail announced that she accepted a position in the Bush White House and went to do that. I didn't really want to be the Administrator. Frankly, I believed the election was not going to turn out favorably for Mr. Bush.

I believed that his chances for re-election were going to be not good. I had a job offer from Merck Pharmaceuticals. I had already told the Secretary I didn't want to stay. And they were looking for somebody else anyhow. They knew I didn't want to stay. Gail and I had a good relationship with the Secretary's people. However, every Secretary wants to fill jobs with their own people. We were put into the HCFA job by the White House. Gail was not selected by the Secretary. I was not selected by the Secretary. We were selected by the White House. So I think this was an opportunity for Secretary Sullivan to put his own people in, to put his own stamp on that job, and he did for the period of time up until the election.

Berkowitz:

I see. Did you leave HCFA with any impressions about Medicare and Medicaid that are still with you today and you still use?

Hudson:

Oh, absolutely. I have very strong impressions mostly about Medicaid. For the last 10, 15 years my interest has been looking at how to rethink the Medicaid program. One of the things from my experience as the head of the SWAT team in HCFA was to think through with people how it could be reformed. What would you do to change Medicaid for the better? People look at you when you ask that question and they scratch their heads. They don't know.

Part of what I learned from HCFA was that there are delivery of care options available, and in the state Medicaid programs it's possible to get individual Governors to think through with you how to deliver care differently.

When I came back from Merck and started my own company, one of the things that I did specifically was work with state Medicaid programs to the extent I could. I worked for Governor George W. Bush and then I worked for Jeb Bush, his brother in Florida, because they were interested, more Jeb Bush than George W. Bush.

Jeb Bush was very interested in understanding how delivery of care could be reformed in the Medicaid program. He is extremely, extremely knowledgeable about the intricate operational aspects of Medicaid in his state. I've never seen anybody who knows as much about how Medicaid works as Jeb Bush does. We worked closely with him on trying to integrate into his Medicaid program pilot programs that would deliver care to people with chronic illnesses using disease management programs. For many people with chronic illnesses, states hemorrhage funds into programs.

The so-called dual eligibles are hugely expensive and getting more so.

I could go through a whole lot more detail about that, but my interest in the time that I left government and started my own company was in trying to understand how we could give

states incentives to deliver care differently without doing the gaming that was going on when I was there. And there was an awful lot of interest in doing so.

I discovered if you don't have a Governor who understands how it should be reformed, or doesn't have a roadmap on how he wants to reform it, then you have an uphill battle because Medicaid is so complex. State legislatures don't really understand how it works and don't want to. All they know is that CMS and OMB sit atop anything they want to do, and any innovation they come up with must have the approval of CMS and OMB who require a budget neutral way of looking at pilot programs. And, unfortunately, that is still going on.

Most of the innovation in Medicaid is coming along now because the states are cash-strapped. Texas spends almost 30 percent of its state-only budget on Medicaid. It had to do something, and it's doing exactly what I advocated it should do five or six years ago. It recently set up a pilot program for the duals. It's a complicated program, but the way they have set it up, I believe, is any savings from the program in the pilot they're running, they share the savings with Medicare, which is the way it has to work.

The biggest piece of any state Medicaid program spending -- certainly in the large states, Texas, California, Florida -- is on the duals, people who are eligible for Medicaid and Medicare. That's where all the money is, where the state has to spend money.

If you can find a way to reform that program, deliver care better -- this isn't cutting programs-- then you have an opportunity to show savings. That's where I think we hopefully will be headed in the future. The Affordable Care Act has created so much uncertainty out across the states and it is so politicized now, I wonder if we're not going to be a long time in getting reforms in place that really should go forward.

Berkowitz:

Well, I'd love to check back with you on that in the future. Thank you very much for doing this interview.

Hudson:

It's been my pleasure to do so.

Interview with Herbert B. Kuhn

By telephone on May 6, 2015

Interviewed by Edward Berkowitz

Transcript edited for clarity.

Berkowitz:

Today is May 6th, 2015, and this is a telephone interview with Herbert Kuhn, who is in Jefferson City, Missouri and is the President and CEO of the Missouri Hospital Association.

I want to talk to you a little bit about your life, your biography, and also a little bit about health policy in your work at CMS. I see that you have a Kansas background and that you went to school at Emporia State. What part of the state did you grow up in?

Kuhn:

I mostly grew up in the central to eastern part of the state of Kansas.

Berkowitz:

Okay. And you went to college, and eventually you went to work with a Kansas congressman whose name was Bob Whittaker?

Kuhn:

That is correct.

Berkowitz:

Could you tell me how that came about?

Kuhn:

Yes. I got involved with him back in 1978, when he was first running for Congress. I was in college at the time. I took a semester off from school and worked full-time on his campaign. I went back and finished college; then I managed his reelection campaign, and when he was reelected I came to Washington, ostensibly -- like a lot of folks -- just to stay a few years and wound up staying 30.

Berkowitz:

I see. So you had a case of Potomac Fever then, as they say.

Tell me a bit about the sorts of things you did with the Congressman. Were you just handling correspondence, or did you have a particular area of specialty?

Kuhn:

Like a lot of young folks that start on the Hill, I was started out in the correspondence area. I had light legislative duties -- principally tax and agriculture, issues like that. He ultimately got on the Energy and Commerce Committee and ultimately on the Health Subcommittee. He was an optometrist by background so he was a health care professional. And I then

moved over and handled that portfolio for him on the Energy and Commerce Committee, and that's how I started getting involved in the health policy world.

Berkowitz:

So, did you have dealings with John Dingell's staff, then?

Kuhn:

Yes.

Berkowitz:

What was that like?

Kuhn:

It was actually a good group to work with, along with Henry Waxman's staff, as well. Those were the days -- obviously there was partisanship, but it was a heady time in health care. That's when Henry Waxman and John Dingell were the raging incrementalists and fundamentally changed the Medicaid program during the decade of the 80s. It's when we saw AIDS enter into the realm of things; it was a time of many Congressional hearings and activities related to that public health issue. And it was the time of the Stark laws and when prospective payment systems came into the Medicare programs. So it was an interesting time to be on the Hill in the '80s. And, also, it was an interesting time in that there was a lot more collegiality among the legislators. While they were on opposite sides of the aisles, they found lots of opportunities to work together on specific issues. It was a good time for me to learn the trade, so to speak.

Berkowitz:

Although John Dingell and Henry Waxman I think of as particularly partisan, they were okay to work with as minority staff?

Kuhn:

Absolutely. They knew how to count votes. They'd know when they needed folks from the other side. They'd know when they didn't need you from the other side. They knew when you had a reasonable idea, when you didn't have a reasonable idea, and there were always those opportunities to work together.

Berkowitz:

I see. So you got a chance to observe Congress in action. I was wondering if any people struck you as particularly gifted in this area of health, other than Dingell and Waxman.

Kuhn:

Yes. Over on the Ways and Means Committee it was always fun to watch Pete Stark. He was a bit fiery at times, but nevertheless was someone who knew how to get things done. Bill Gradison was another one at the time who I thought was a very thoughtful legislator on the Republican side. On the Senate side, obviously being from the Kansas delegation, you got to watch and work a lot with Bob Dole, with Sheila Burke, and folks over there, and that was always enjoyable and a great learning experience as well.

Berkowitz:

After working in Congress, you went over in 1987 to the American Hospital Association, the AHA, where you spent a substantial number of years -- 13 years, I believe. How did that appointment come about?

Kuhn:

They actually approached me. I was working on the Hill there for my boss on the Energy and Commerce Committee. They reached out to me with an opportunity. It was an interesting portfolio of issues to cover: more public health and Medicaid issues, rather than Medicare issues.

I had been working with the Energy and Commerce Committee, where I had cut my teeth and working with what now they call the HELP (Health, Education, Labor and Pensions) Committee, over on the Senate side. I'd spent nearly seven years on Capitol Hill.

The job at AHA was an opportunity to transition into something else, into the trade association world, and I guess become one of those lobbyists.

Berkowitz:

I see. So, in your work in Energy and Commerce Committee, you probably worked much more with Medicaid than with the other government programs, is that correct?

Kuhn:

Yes. You always have kind of a large portfolio with folks on the Hill, but Medicaid, obviously, was the principal thing on Energy and Commerce, as was Medicare Part B -- physician payment, and some of other things.

Berkowitz:

Could you explain that to me a little bit, because I understand that the Energy and Commerce Committee got hold of Medicaid and took it away from the Ways and Means Committee, but I didn't know about the Part B side of things?

Kuhn:

They've always had split jurisdiction there, so over at Ways and Means they of course have Medicare Part A and Part B, at that time, and then ultimately now with the change of things, Part C, which is of course the MA (Medicare Advantage) plan. And then ultimately Part D, the prescription drug benefit. The Energy and Commerce Committee, in those days, always had joint jurisdiction on Part B, so that was split jurisdiction at that time, and my understanding is it continues to be to this day.

Berkowitz:

I see; sounds very messy.

Kuhn:

It sometimes created interesting situations. When you went into a conference with the Senate, you could have three different proposals moving forward. You could have two from the House -- one from Ways and Means, one from Energy and Commerce, and then ultimately one from the Senate. So it was sometimes even a three-way conference.

Berkowitz:

The Senate Finance Committee didn't cede any of these programs to other committees, is that correct?

Kuhn:

That is correct.

Berkowitz:

So it would suggest that they had more influence in those conference committees?

Kuhn:

They were at least more unified.

Berkowitz:

I see. Could you tell me about some of the other issues that you worked on for the American Hospital Association?

Kuhn:

Sure. As part of the portfolio we got a lot into environmental issues. There became a major movement in the '90s on sustainability with health care. There were environmental issues such as how hospitals managed their medical waste -- incineration, the autoclave, different things like that, as people were worried more about infection issues.

Those were the heady days when people were finding lots of garbage being washed up on some of the more pristine beaches of our nation, and some of it included medical items. So that was a challenge working on those kinds of issues. I continued to work on the AIDS issues up through that time in the late '80s and early '90s. And then the role evolved. I was becoming more and more involved in the day to day issues of the Medicare and Medicaid debates. So I moved beyond just public health and Medicaid, into more frontline Medicare policy work.

Berkowitz:

I see. I suppose there's a hospital in every Congressional District, or at least in most of them, and I was just wondering how you went about presenting the position of the American Hospital Association. Was it your style, or was it the organization's style, to bring a local hospital administrator to Washington and testify?

Kuhn:

Sure. Generally, you always want those connections from back home. The professional paid lobbyists and other representatives in D.C. are good, and they can develop those relationships with both congressmen and senators, and their staff. But it never hurts to have that linkage back to the home district. So, where you could, you would always try to make that linkage. Where you couldn't, you presented the information in a couple of different ways. One, what was the impact of the policy, given the bases of information that the Association had? And then, of course, you would try to make the transition to what it meant for them. What did it mean for their Congressional district and/or their state, to

show how that policy could impact in a positive way, or what to do to avoid unintended consequences? So, you would always try to put the local spin on whenever you could.

Berkowitz:

Do you remember making lots of visits to offices, or was it mostly preparing for testimony before committees?

Kuhn:

A little of both. We made lots of visits. There was lots of walking the halls working with both the staff and individual offices as well as the professional staff on the committees. And then there was helping folks prepare for testimony, and doing briefings, doing just the whole thing from soup to nuts.

Berkowitz:

So, were you scouting for the American Hospital Association as you went through those corridors of Congress, and saw the younger staff members?

Kuhn:

You were always looking for new talent. Absolutely.

Berkowitz:

I see. Now let me talk to you, if I could, about your work at CMS, which I believe began in 2004.

Kuhn:

That's correct.

Berkowitz:

You were hired as Director for the Center for Medicare Management. Could you talk a little bit about that appointment? That's kind of different thing than you'd been doing. Was there someone in the White House or someone that helped you get that position?

Kuhn:

Yes. It's interesting -- I don't know the whole story still to this day. But what I recall is Congress had just passed the Medicare Modernization Act at that time in the fall of '03.

I got a call one day out of the blue from the White House, from the Office of Personnel, saying my name had come up from a number of different folks as an individual who could probably help them implement this new law --this really new transformational law that had been passed, and was I interested? Well, you only get those calls once in a career, and of course I was interested. And so I followed up with them, did the requisite interviews over at the White House. They checked the appropriate references. And by February of 2004, they asked me to come over and be the Director of that center.

Berkowitz:

I see. And that was a presidential appointment?

Kuhn:

That's correct.

Berkowitz:

What does the word "center" mean at CMS?

Kuhn:

It was part of the reorganizational activities that CMS had put together. Obviously during that prior couple years, they had transformed from HCFA, the Healthcare Financing Administration, to CMS, and under CMS, they created those three different centers. The Center for Medicare Management was the fee for service side. There was a second center that dealt with the health plans, then the new Medicare Advantage Plans. And then, the final one was Center for Medicaid and State Operations.

Berkowitz:

I see. Was it a big pay cut to go over to the government?

Kuhn:

Yes, it was.

Berkowitz:

But you figured it was worth taking?

Kuhn:

It was a wonderful opportunity. Yes.

Berkowitz:

I see. When I think about this Center for Medicare Management, I have a picture of Medicare operations and in particular of paying providers the right amount for the right services. Is that the mission of this center, or is it more complicated than that?

Kuhn:

I think that's part of it, but there's a little bit more to it. In part you're right. It is kind of making sure that the policies are getting their intended purposes out there. And one of the challenges of that is that the Medicare program is a large program. It's a program that wants to operate by a single set of business rules all across the country. And one of the challenges of that effort is how do you put together a program that can operate as closely to a single set of business rules, but understand that each community, each state, is going to have a bit different or unique circumstances. So maintaining enough flexibility to deal with those particular issues, but at the same time maintaining the discipline of a large program that does, as you said, pay accurately, and pays fairly to folks that are out there is a challenge.

The other big part of that center was the day to day operations. How do you manage all those things in a way that you can do the appropriate provider education, the appropriate information to all your contractors, so they're all implementing in the same way all across the country?

It sounds simple, but it is extraordinarily difficult to get that all synced up at times.

Berkowitz:

I see. Would you say that we have one Medicare program in this country, or are variations in the different states so great that the program's actually quite different in places?

Kuhn:

It's largely still one program; I think that discipline has stayed in place, and I think it is useful for the program. There is some variation; the Medicare contractors have some discretion through local coverage determinations to make some differentiation in some areas depending on certain practice patterns, or the way people practice medicine in certain areas, or utilization of certain drugs in different ways, or medical devices. But, largely, they continue to follow a pretty good standard of one set of business rules for the program. And I think that makes sense, because when you get into variation across the country, when you start making exceptions, you kind of lose control of the program, and the program then could become more managed by political imperatives.

Berkowitz:

I see. So when the program was created in 1965, and started in 1966, Medicare Part A and Part B had different systems for paying the providers. One was called fiscal intermediaries (for Part A claims) and the other was called carriers (for Part B claims). As I understand it around the time you were there, there was an effort to standardize that operation so that instead of having one agency that worked in a particular state or region to pay Part A claims, and another to pay Part B claims, they would try to unify those things. I think they are called "Medicare Administrative Contractors." Is that correct?

Kuhn:

That's correct. I managed that process, or it was in the shop that I was in. And it was what we called "contractor reform," something the agency had wanted for two decades. Up to then, we had the fiscal intermediaries, and others -- nearly 50 of them across the country. Some of them covered all relevant providers in a state. Some of them only covered partial parts of states.

It was a challenge to manage all those different contractors and make sure they were all operating in the same way and getting the efficiencies the program needed. So there was an opportunity not only to come in with a more limited set of contractors, but also to put a set of performance incentives in place which we'd never had before in that area. We wanted performance incentives in terms of the quality of the work, the accuracy of their work, and different things like that. We went to a bidding process where previously most of them just came up through legacy contracts. So, it gave us a chance to go through that whole contracting process, and it surprisingly went quite smoothly. People were really pleased with the process, had very few challenges along the way -- did have some, but few. And there was very little political interference of the process, and it seemed to go quite well, and I think the program is stronger as a result of it. The reason it went so smoothly was the great work of the career staff. They managed the process in a very professional and open manner.

Berkowitz:

I see. Did you have people in the agency, in CMS, who would work the claims themselves and then apply error checks?

Kuhn:

There is an error rate system within the program that's run by the Office of Financial Management that looks for the error rate. But that in-house system is based on the performance metrics that are given to the contractors. They manage the actual claims.

Medicare has probably about a million providers they pay, and probably process well over a billion claims a year. For the agency of about 5,000 people with a smaller part of that operating the fee for service side -- for them to process or manage that claim area is not possible; they just can't do it. That's why it's all put out to contractors. But through audits, through performance metrics, other reports, the agency is pretty well able to stay on top of those contractors' performance.

Berkowitz:

I see. I've looked a little bit at the original set up of the structure, and from the beginning there were heavy political considerations like the Mutual of Omaha would have a contract in its area, and so on. And from the very beginning there were contractors that were actually less good than other contractors. Were you part of those kinds of political negotiations?

Kuhn:

Well there were the legacy contractors that we had when I got there. And then we transitioned to the new MACs, and, yes there were a lot of briefings on Capitol Hill. I did a lot of those to make sure folks knew what we were doing, to help people understand the process. Obviously those that were competing for the business were up talking to their legislators about the process, but there was very little political interference in that process. It seemed to work extraordinarily well, maintaining the integrity of the program.

Berkowitz:

Were these contracts that were heavily sought after? Was it something that the insurance companies or the other organizations could make money on?

Kuhn:

They thought so. There was a lot of early interest in the process. When we had the early kind of bidding conferences, where we were doing educational information, we had really good attendance, not only from incumbents, but from new folks who wanted to break into the space. Ultimately, when it came down to actually putting in bids, that thinned a few of them out.

Berkowitz:

I see. You had several positions at CMS, including being the Acting Administrator at one point. Could you help me get those straight?

Kuhn:

Yes. I came in as Director for the Center for Medicare Management. And then shortly after I came on Mark McClellan came on board and was confirmed as the new

Administrator. So you had Mark as Administrator, Leslie Norwalk as the Deputy Administrator, and then the three center directors. Then, when Mark left, Leslie was brought up to be Acting Administrator, and they approached me to step up and assume the role of Acting Deputy. So I moved into the Acting Deputy and held both the center job, as well as the Acting Deputy job, during that time. Then, ultimately, Leslie left when her time came, and before Kerry Weems came on board there was about a four month period when I was Acting Administrator as well.

Then Kerry came on board, and I was then permanent Deputy and let go of the Center for Medicare Management. And then, finally, in '08, Dennis Smith, who had been there from the very beginning as the Director of the Center for Medicaid and State Operations, left. And so, then, I had two roles at the end: I was Acting Director for that center, as well as then the Deputy Administrator at the end. So I basically had every role there, except for directing Health Plan Management.

Berkowitz:

I see. Might you talk a little bit about Mark McClellan?

Kuhn:

He was absolutely terrific. Not only a very gifted intellectual, who had both his medical degree and his Ph.D. in economics, both from Harvard, but he was just a really solid Administrator as well. He brought the whole package to play when he came to work there. He came over from FDA so he had some good experience there with dealing with a large bureaucracy. He had spent prior time at the White House, so he knew a lot of folks there. Not only was Mark a very powerful person intellectually, he knew the bureaucracy. He had the contacts up and down the line -- at the White House and at various agencies within the Department of Health and Human Services.

He had a good touch as one of the people who could translate some of the difficult policy issues that we were dealing with into something meaningful for policy makers who were not experts in the details. He could brief everybody from the Secretary to folks over at the White House, to folks on Capitol Hill, in a way that made things understandable. At the same time, he was able to advance our policies and our positions.

Berkowitz:

How did he get along with the career people?

Kuhn:

Very well. He was well thought of and well-respected by the career staff.

Berkowitz:

Interesting. Thinking about the various jobs you held, what was the difference among them? What does the Acting Deputy do?

Kuhn:

The Acting Deputy -- it's almost a distinction without a difference from the person that had the role before. But the Acting Deputy almost operated as the chief operating officer for the organization. You dealt with a lot of the general operation issues of CMS: budgeting

issues, appeals issues related to what administrative law judges were hearing cases against the agencies, things like that. And oftentimes, you'd serve as the principal liaison with other agencies -- the Department of Justice, FBI, the Inspector General -- in terms of investigation reports, things that they were working on with the agency there. At times you would be spending an awful lot of time up on Capitol Hill either testifying or helping doing briefings on different issues. So, you would get involved in a lot of different elements of the agency and then also fully participate in the briefings for the Secretary or others on some of the things that we were doing. And then, finally, a lot of times, it would be the person who would have a lot of the role in terms of working closely with OMB and others at the White House, as you were trying to get your policies moved forward, or importantly get certain regulations cleared in time to get them published in the *Federal Register*.

Berkowitz:

I see. So it sounds like there are some Baltimore things, working with the folks there and being the chief operating officer of the agency, and some Washington things, like working with OMB and the Secretary. So, did you spend most of your time when you were in that role in Washington?

Kuhn:

Yes. I would be probably three days in Washington, two days in Baltimore.

Berkowitz:

I see. Let's talk about your appointment as Acting Administrator. Could you talk a little bit about how that came about? Did you have a champion inside the White House or just how did that come about?

Kuhn:

You know, I don't think it was terribly complicated, quite frankly. It was just the fact that they were looking to make a smooth and easy and clean transition from when Leslie left until they could get Kerry totally vetted and confirmed as part of the process. And so, I had been around for a while; I knew a lot of the folks up and down the line at the HHS and at the White House. That had, I hope, instilled confidence, and trust, so they thought I would be someone who could keep the trains running so to speak during that interim period. And I think that was kind of the sum and substance of it.

Berkowitz:

So, when you had this role, was there any discussion of you stepping into the role permanently and trying to get you confirmed, or no?

Kuhn:

Nothing of that. I think I had some friends who maybe aspired to that [laughs] but there was no active campaign on my part, or anybody else's to make that happen.

Berkowitz:

I see. In this role at the very top of the agency, as the Acting Director and the Acting Deputy Director, do you remember any particular sets of decisions, or policies that were particularly difficult?

Kuhn:

I can easily remember a couple that were pretty difficult at the time -- one having to do with an issue out in Los Angeles. You may recall back in '06, '07, the problems that Martin Luther King Hospital was having at the time.

Berkowitz:

Yes.

Kuhn:

It was a hospital that was getting a lot of national attention where there was a lot of bad care. There were videos of people lying on the floor in their emergency department for 45 minutes, and even janitors coming around and mopping around these people, and it was an ongoing challenge working that through the process -- getting it so that we continued the survey and certification process, having enormous pressure from the California delegation, and particularly folks out of Los Angeles to keep this particular hospital open for a whole variety of reasons. We were trying to do the right things for the program and those people who were being served. Ultimately, at the end of the day, it was my decision, and my recommendation that the hospital be closed, and so we effectuated that.

There was another one that had to do with a coverage determination at the time where we were dealing with erythropoietin, or EPO. It's a drug that's used to help people who have anemia. It is used mostly in ESRD (end stage renal disease), for people who are in renal failure and going through renal dialysis. But also it's used for patients who are going through chemotherapy who develop chemotherapy-induced anemia.

We were starting to see at our shop some early evidence that perhaps that particular drug was spurring progression of the cancer. It was restoring the red blood cells, and dealing with the anemia, but also counter-acting the chemotherapy. We did a national coverage determination, took comments. I can't tell you how many meetings I had with folks on Capitol Hill, with physicians coming in, with drug manufacturers and others lobbying hard against that issue.

FDA was involved but had not yet done their black box warning on it. We had a number of clinicians, career folks at CMS, who had looked at the evidence, believed strongly in it, were making some pretty strong recommendations, and ultimately it was our decision to do the coverage determination to limit use.

I remember one particular doctor who really understood how to communicate on issues like this. He said in one memorable meeting, "This stuff is nothing more than Miracle-Gro for cancer. It really adds to the progression of the cancer, and it actually grows the tumor."

That was an enormous decision, but we made it. Ultimately it was the right decision, and it was good for those who were trying to fight cancer. But it was extraordinarily difficult.

Berkowitz:

In the first case, the closing of the Martin Luther King Hospital in Los Angeles, when you say closing, what is the mechanism? Do you mean to say that you wouldn't provide Medicare reimbursements to that hospital?

Kuhn:

Right. We would withdraw their Medicare certification and neither Medicare nor Medicaid would pay for services in those facilities anymore. We just wouldn't certify them anymore.

Berkowitz:

So they had the option of continuing, but they would have had trouble financing --

Kuhn:

Yes. There's no way they could have survived.

Berkowitz:

And Medicaid as well?

Kuhn:

Yes.

Berkowitz:

I see. And that was agreed to by the state of California?

Kuhn:

Yes. They ultimately came along and said they agreed.

Berkowitz:

I see. That's an interesting thing. The politics around the hospital must have been intense.

Kuhn:

It was huge. Not only did you have a hospital in a predominately African-American community, it was a major employer. It was a major union issue. It goes on and on and on.

Berkowitz:

Now, on the second issue you talked about; it was a drug. What was the mechanism there? Was this a Part D issue?

Kuhn:

No, that drug came under Part B.

Berkowitz:

I see. So the mechanism would be that you wouldn't reimburse hospitals for the provision of this drug.

Kuhn:

Yes, for the indication in question.

Berkowitz:

I see. So that was enough to knock out the use of that drug.

The regulatory clout is quite strong there. Were there other groups that were using the drug that might benefit from it?

Kuhn:

The drug has a lot of different uses. Obviously this was an important drug. In the 80s, the only way you could really deal with anemia in many different areas was transfusions. But with the AIDS crisis, transfusions were a major way of transmitting AIDS to people

When this drug first came out, it was seen as a miracle because it was a way to deal with anemia. It was promoted not only for anemia in people going through renal dialysis, but also ultimately for people with anemia induced during chemotherapy. But we found that it could actually spur the growth of cancer, and just have the opposite impact of what you were trying to do with these very toxic cancer drugs. And so we restricted the use, and I will tell you that was a challenge, but it ultimately was the right thing to do.

Berkowitz:

Let's talk a bit now about your career after CMS. I know that you went to the Missouri Hospital Association which is obviously in Missouri, so that would mean leaving Washington. How did this association job come about?

Kuhn:

When I finished things up in January of '09, I had some down time; I started doing some consulting, started pursuing some additional opportunities there in D.C. and had fully intended to stay in that area. But a couple things happened. One is I got on MedPAC and become a Commissioner on the Medicare Payment Advisory Commission. That gave me a platform to continue to contribute to the Medicare program and to stay very involved in the policy world.

And then, as I was putting together different opportunities, out of the blue, I get a call from a head hunter about this opportunity out here in Missouri. Obviously I knew about the state hospital association having spent some 13 years prior with the American Hospital Association; I knew what they did, what was out there. And then, also I have aging parents, as does my wife, who's also from Kansas. We said, "There might be an opportunity here." It seemed a chance to go home, to deal with care for family, but also still stay linked to Washington through MedPAC. So ultimately I made that decision to leave D.C. after 30 years, and move out here to the Midwest.

Berkowitz:

You're in Jefferson City, which is a bit far away from your home state Kansas?

Kuhn:

Yes. I can be over in Kansas in about two hours, but it is a little ways away.

Berkowitz:

Are most of your members from Kansas City and Saint Louis?

Kuhn:

They are statewide. We had about 154 hospitals in the membership from all parts of the state of Missouri.

Berkowitz:

I see. Before getting into that and going back to MedPAC, did that give you an opportunity to get to know Gail Wilensky?

Kuhn:

Yes. I knew Gail before, but her time on MedPAC preceded mine.

Berkowitz:

I see. Was she somebody you talked to about CMS issues?

Kuhn:

When I was at CMS we had more interaction; we had interactions every now and then, with her work at Project HOPE. She's just an extraordinary person with great expertise in so many of these different areas.

Berkowitz:

Were there other people like that that you -- when you were at CMS -- would call that weren't in CMS at the time, but had experience?

Kuhn:

Yes. There were several folks that one would try to engage with, that you could talk to. Obviously there were different folks in the agencies, different folks on Capitol Hill that you knew from your experience -- from prior experiences there. There were former CMS staff that were out and about in consulting roles. And there were others around the country that I knew had certain subject matter expertise in different areas. It was good to talk with people outside to assess how a policy was working, to get some sense if we were starting to see implications of a new policy; we were looking for early warning systems out there.

I think the worst thing that can happen at CMS, or any federal agency, is if you lose your sense of self awareness, and have a tin ear about what you're doing and how that's impacting the people out there. While the agency itself has a pretty good surveillance system, I think any good political officer needs to have their own and needs to be constantly checking on the temperature--not only around Washington, but around the country.

Berkowitz:

When you were the Acting Administrator, did you ever say to yourself, "I wish I was actually the confirmed Administrator, because I could get much further with the Department or with Congress"?

Kuhn:

No. That was just not where I was at that time in my career.

Berkowitz:

And it wasn't a limitation to haven't actually have been confirmed?

Kuhn:

No. It was, at the time, truly was a distinction without a difference. I think a network of contacts and knowing how to work through the system to get things done can help you in so many different ways, as well.

Berkowitz:

I see. So if Robert Dole had still been in Congress, he would have been just as fine interacting with the Acting Administrator as with the actual Administrator?

Kuhn:

Yes.

Berkowitz:

And that's true of others, too?

Kuhn:

Yes. We saw that. I know I saw that with Leslie Norwalk when she was Acting Administrator, and ultimately with Kerry Weems when he was Acting Administrator. He was nominated by the President, but Kerry was never confirmed by the Senate. He did have a confirmation hearing, however, but it was, again, with them, a distinction without a difference. They were able to function fully in their jobs, and command the respect and make the decisions, and everybody knew they ultimately were the decision makers, so that's who they wanted to talk to.

Berkowitz:

I see. Let's talk a little bit about your present work now. Obviously the Missouri hospitals would be concerned about Medicare Part A and Medicaid as well, as it operates in the state of Missouri. But are there some uniquely state issues that have now come into your life that weren't there before?

Kuhn:

Yes. There are some. Medical liability reform based on a recent State Supreme Court decision has moved up. On the Medicaid front, Missouri is a very red state, and it's one of those states that have yet to do Medicaid expansion. So that has continued to be a challenge and an issue we face out here. An emerging issue is what happens with the issue regarding having a state or a federal based exchange. We are a federal exchange state, and of course, everybody's sitting on pins and needles waiting for the King-Burwell case decision by the Supreme Court next month, and what that will mean in terms of coverage for people who are getting subsidies through the marketplace. There are also a lot of workforce issues at the state level that emerge, and there are Certificate of Need type issues. There continues to be a large portfolio of issues, and as they always say, states are the laboratories where health care evolves; Missouri's no exception.

Berkowitz:

Am I correct in thinking that Medicaid expansion is something that your members would like?

Kuhn:

Yes. Very much so.

Berkowitz:

How does Medicare look from where you now sit? Does it look different?

Kuhn:

Yeah, it does. I really like where Medicare is going.

If you go back to when Tom Scully was head of CMS, Tom used to always say, "Medicare is nothing but a big dumb payer." Not the most articulate way to say how Medicare works, but an accurate assessment. When I was there with McClellan, we used to always say, "Medicare needs to begin to change, and Medicare needs to be an active purchaser of high quality, efficient care. It cannot continue just to pay claims as they come through the door. It needs to become an active purchaser." That's what you're seeing with the Medicare program now, particularly as a result of many of the policy changes that were part of the ACA.

But some of this was also started with some of the precursor policies that we had when Mark was there, when I was Acting, when Leslie was Acting, when Kerry Weems was Acting, and also when Michael Leavitt was Secretary.

We're really starting to see the Medicare program become an active purchaser, which I think is nothing but good, not only for Medicare beneficiaries, but for the program, and ultimately for providers. I think the whole movement away from volume to value makes all the sense in the world, and I think the Medicare program is going to be stronger for it and better in the future.

Berkowitz:

Is that an issue on which you have to lead your members? I can't imagine they'd be too thrilled about a new system that might end up paying them less.

Kuhn:

You get mixed opinions. As in all things, you'll always have your set of early adopters who are going to recognize the future opportunity to get ahead of the crowd and move forward. You'll have those kinds of followers who will move along when they see others test it and move in that direction. And then, ultimately, you'll have a set of reluctant followers trying to figure out where they fit into things. That was always the case in everything that I've seen in health care, and this one's no exception.

Berkowitz:

I see. Did you have to learn a lot about Missouri politics, as opposed to federal politics when you took the job?

Kuhn:

The politics are different, yes. Obviously at the state level it's much more retail. Legislators are much more accessible. State officials are much more accessible -- good

conversations with all. Just having an opportunity to get really thoughtful one-on-one engagements with these folks has been very useful, and a change.

Politics are everywhere, and if you look at all kinds of things within these fields, it's always three parts. One is the policy, the second is the politics, and the third is the process. Policies are still pretty much the same. It's the politics and the process that are a little bit different and those are the things you just have to learn.

Berkowitz:

My vision of the state legislature, which is not particular to Missouri, is that they have other jobs. It's not a full-time job, and they're not there all the time. They only come when the legislature is in session, which in some states is only a couple of months. Is that true in Missouri?

Kuhn:

Yes. It's no exception. It is a part-time legislature with many varied backgrounds and professionals that come in to serve in a general assembly.

Berkowitz:

So then, if you want to talk to somebody, does that mean going off to his farm, or his business?

Kuhn:

You could meet in a lot of different places. I've had meetings in Starbucks restaurants with folks, in their communities. I've met in their businesses. I've met in their law offices. Or I met with them in their offices up at the Capitol. So, it's a little different in that regard, and actually it's kind of fun.

Berkowitz:

We've already talked a bit about the Affordable Care Act, which obviously changes the environment for hospitals, and doctors. You've talked about the Medicaid expansion and some issues with that here. Would you say the ACA and its implications are a big part of your job now; has that changed your job a lot?

Kuhn:

It changes the emphasis of where we are; I think everybody's emphasis in health care changed as a result of the ACA. Everybody went from an environment where they were advocates for more healthcare coverage, for universal coverage, or whatever the case may be, to now an environment where it's kind of full implementation of the Affordable Care Act, and all the dimensions of that.

I think we all got moved in 2012, when the Supreme Court made the decision that the Medicaid expansion was an option. That changed everything. Now you have a number of different states -- I think 29 -- which have done the Medicaid expansion, the rest that haven't. We're one of the 21 that haven't.

How do you put together a program that can convince people to do something that they really don't want to do, and they're pretty stubborn about? As I say, "How do you change

stubborn?" It's pretty tough in that environment, but it's a conversation we continue to have here in our state. And then the new layer of the issue which could also be a game changer for us is the King-Burwell case and what may or may not happen with the permissibility of subsidies to come through the federal exchange in the future.

Berkowitz:

Is the argument against being part of Medicaid expansion that although it looks like there are strong financial incentives to do this at the present time, those incentives will eventually go away, and it'll become a very costly endeavor for the state, or is there some other political dynamic?

Kuhn:

That's certainly one of them. The argument goes, "It sounds good now, but we'll be left holding the bag in the future." It's the cost issue there. But, the larger issue is that it's part of the ACA. It's part of Obamacare. And if you're a politician who's campaigned against Obamacare, have campaigned for the repeal of it, the whole motion that you might move to implement any single part of it becomes a real challenge. That's a large part of the dynamic here.

Berkowitz:

So perhaps it would have been better for the states if they said, "Well, we have to do this. We don't want to do this, but we have to do this." That's what Southern hospitals said when they had to integrate after Medicare; they said the Feds made them do it. But it's a different political dynamic to say, "We're making the active choice to have this program."

Kuhn:

Right. And that was the result of that now famous decision by the Supreme Court.

Berkowitz:

Right. As you get a little bit older, although I don't think you're all that old yet, but you may have friends and colleagues who are Medicare beneficiaries -- do you get a lot of feedback about the experience of actually being on Medicare?

Kuhn:

I do. It's funny you say that. Many times as I've traveled around the state of Missouri I've talked to folks who are on Medicare and as I've spent more and more time in some of these hospitals, and particularly with some of these line managers there, I look back at some of the decisions that we made when I was at CMS. I reflect on the fact that if I had had some of the experiences I've had over the last five years here in Missouri, I think I could've done my job better at CMS, because I think I would've had a greater appreciation for what was going on there.

To a degree I had some of that when I was at CMS. I was part of that generation that grew up when it was HCFA, and of course HCFA stands for Health Care Financing Administration. We used to always say on the outside is that it really stood for is "Here Comes Further Aggravation."

[laughter]

I would tell the CMS career staff that that's what folks thought on the outside. I said, "We have to change that perception." I became a champion of the development of a preceptorship program; I really wanted the staff to spend more time in the field with those that they were regulating. If you are writing a regulation on outpatient payment, you need to go spend two or three days with the coders and the people that are implementing this program so you have a better appreciation, understanding of that.

Of course, the first push back I got is "We don't have the travel money." And I said, "I'll find the travel money." And then the word got to me that some were saying, "Well, he thinks he's such a smart guy to do this. Let's see him do it first."

At that time we were putting the risk adjustor in for renal dialysis facilities, and so I got the team that was putting it together, and we spent two days going to renal dialysis facilities on the East Coast, so we could understand some of the issues better.

So I really pushed that hard, and not only folks out of the D.C. office, or the Baltimore office, but I wanted the regional offices to do that as well, because I thought that was such an important part of the program. And I still think about that part of the program now as I go around and I visit hospitals, and I see how part of the Medicare program works, and I think, "Gosh. If I knew some of that stuff, or someone was in that preceptorship program that could see this, maybe we could get the program to work better."

Berkowitz:

Last question, if I might -- what changes do you see coming down the road for Medicare and Medicaid in the future?

Kuhn:

I think there should continue to be movement towards value and away from the volume part of the program. Efforts should continue to find ways for the Medicare program to be an active purchaser of care, of high quality, efficient care, instead of just a passive payer simply paying the claims when people get sick. I think we've crossed that bridge. It's just how fast can they accelerate those things and make that happen in a way that's fair to everybody, so that they believe in the program, and that it works.

One of the challenges Medicare is going to have as they continue to push in that environment gets back to an issue we talked about earlier. We want to run this as an equitable, effective national program. There are going to be issues that crop up, like social-economic status that some think need to be in the risk adjustors but CMS is resisting. The real challenge for the future for CMS and the Medicare and Medicaid programs, is can they continue to maintain a sense of self awareness, understand where their programs are going and be in a position that they can adapt and move those programs so that providers and the beneficiaries continue to believe in them? The challenge is that they be ready for changes, can implement changes effectively, and get the results they want.

That's part one. The second part, the real challenge for the program, is the changing demographics in the Medicare population -- the aging in of the Baby Boom population.

Berkowitz:

People like me.

Kuhn:

It started in 2011, and it'll go until 2029. They're aging in at a rate of 10,000 a day. Medicare right now is at 54,000,000 people. In 2030, in just 15 years, it's going to be 80,000,000 people. That is going to be huge. That's going to be a real challenge from a number of different dimensions. The number of people supporting the program on their taxes right now is 3.3 people per Medicare beneficiary. In 15 years it'll be 2.2 people. The population that's aging in are 90 percent white, because that's what the population looked like of the Baby Boomers. But those that are supporting them through their taxes, as well as those that're going to be the care providers, don't look like that population that's going to be part of the Medicare population.

Probably the most explosive part of that Medicare population is that, in the not-too-distant future, we're going to have an awful lot of those folks who are over age 80, over age 85. Their consumption rates of health care services are double those between the ages of 65 and 74. We're going to have an awful lot more of them. We're going to have fewer tax payers supporting them, and they're not going to look like the population that's supporting them from taxes, and they're going to be consuming like crazy. Medicare's going to have to accelerate some of its changes to be ready for that challenge in the very not-too-distant future.

Berkowitz:

I don't have an answer to any of those problems.

Kuhn:

[laughs] I don't know who does, but at least we've identified them. We know what's coming.

Ed Berkowitz:

Right. I think that's a good note on which to end. Thank you very much for doing this.

Kuhn:

It's been my pleasure.

Interview with Mark McClellan

Washington, DC on April 28, 2015

Interview conducted by Edward Berkowitz

Transcript edited for clarity.

Berkowitz:

Today is April 28th and we're in the Brookings Institution. I'm talking with Dr. Mark McClellan.

I want to ask you about your career at CMS and about yourself a bit. Can you talk to us a bit about your family background that included a mom who was the mayor of Austin?

McClellan:

Yes. I come from four generations of very fast talking Texans. My mother was involved in politics in Austin. Before her, one of the biggest influences on my life was my grandfather, her dad, who was Dean of the UT Law School for 25 years, Page Keeton. In fact, the street that runs in front of the UT law school is Dean Keeton Avenue now.

Berkowitz:

He was an expert on torts, I understand.

McClellan:

Yes, an expert on torts and an expert on law in the public service. So we had lots of early cases instead of bedtime stories when he'd come over to visit, and he had a saying that he kind of lived by and that was definitely influential on my mother and my brothers: "It's not the dollars you make; it's the difference you make." My mother picked that up in her career too. She started out as a schoolteacher in civics, not surprisingly, then went on from that to run for the school board because she didn't like the way the schools were working out for the students. She went from being president of the school board to mayor of Austin and then on to a range of statewide offices. Most everybody else in my family is either a lawyer or a politician so that's why I went to medical school. I was going to be the black sheep of the family and get away from all that, and it's funny how things work out. [laughter]

Berkowitz:

It's pretty clear that the law and politics are the preferred professions in your family.

McClellan:

Well, I loved science. I loved medicine. I also loved working with people and I was involved in student government, you know. In college I was the head of our honors -- the president of our honors program -- and did what we called, "The Ideas and Issues Committee" at the University of Texas. But I went to medical school, intending to do a Ph.D.. Originally I was thinking about neuroscience. That's where I did my undergraduate research, but one thing led to another and, by way of some work in biostatistics, because I had done some applied math, I got to know some people in the economics department at MIT who were wondering -- this was around, you know, the late 80s -- they were

wondering why we were spending so much money on healthcare. It was like 10 percent plus of GDP at that point, and how could it possibly be so high? And one thing led to another and I started to work on some projects there. With some of their help I was able to transfer into the economics department at MIT and finished out my M.D. degree, along with a PhD in economics, which was a bit unusual but not unprecedented at the time. I went on from there to do a residency in internal medicine, also in Boston...

Berkowitz:

...At Brigham and Women's hospital?

McClellan:

Yes. It was a hospital that had a real knack for trying to support people who wanted to combine medicine with other interesting pursuits. So I was on call some nights with people like Paul Farmer, who's gone on to do some terrific work in global public health, Jim Kim, who is now the president of the World Bank and various other people who had done some combination of medicine and research or public health or, in some cases, public policy. In fact, we had a reunion for the medical residents who had been in this program, under the same residency director, Marshall Wolf, a couple of years ago, and I think most of the M.D/PhD economists in the country went through that program, at least back in the '90s when I was there. That helped me get going on a career that combined medicine and paying attention to what made a difference for patients with the economic factors and policy factors that influenced what doctors were able to do. My PhD thesis started out being about how the availability of medical technologies at a hospital influenced how heart attacks were treated. But in putting the data together it became pretty clear -- because medical technology availability and other policies like payment, competition, and malpractice laws influence medical treatment decisions -- that was also a good way to learn something about the impact on patient health and cost when the treatments change. A lot of my career has ended up at that kind of interface.

Berkowitz:

So let me ask you too about your many different academic degrees. If you just look at your vita, it's just quite remarkable. It looks like one degree after another.

McClellan:

[laughs]

Berkowitz:

There must've been a lot of taking programs simultaneously to make that be possible?

McClellan:

That's right. When I was in undergraduate I was in an honors program at the University of Texas called "Plan Two" that really encouraged the students to diversify their interests and do things like combine English literature and Biology. Then in graduate school I had a lot of help from my faculty advisors. I was in a joint M.D/PhD program, as I mentioned, with the M.D. being jointly administered by Harvard and MIT. It was a program designed to encourage physicians to develop other skills and, particularly, quantitative skills. MIT was very supportive of my getting into the economics Ph.D. program, of taking some classes at the Kennedy School.

There was a joint degree fellowship program, a Kennedy Fellowship program I was lucky enough to get support from. Because of their help I was able to put together some coursework that spanned technical economics and public policy and medicine that I think is getting to be more of the mainstream in some medical education programs now. There are now master's degree programs that give clinicians some exposure to economics and finance and to public policy. But back then it happened because of the faculty support that I got -- their helping match me up with the best fit programs.

Berkowitz:

It's also an interesting confluence educationally that you were in this innovative program. You're a resident at a Harvard teaching hospital and you happen to be in one of, maybe, the best economics department in the country -- all of which were bundled together.

McClellan:

That's right. Like I said, I had a lot of help in being able to put that together. I'd like to say I went to med school with a plan for doing an M.D. and a Ph.D. in economics and public policy at the same time. But it was nothing like that [laughs].

Berkowitz:

Who did you work with at MIT?

McClellan:

My main thesis advisor was Jim Poterba, who is a professor of public economics there. But then keeping with the spirit of being able to bring things together from the best resources in the Harvard-MIT community, I also worked with David Wise, who is a professor of public economics at the Kennedy School, and Barbara McNeil and Joe Newhouse, who were more based at the medical school, and who were leading some of the health policy work at the time.

Berkowitz:

Newhouse, of course, is an economist?

McClellan:

He is, right.

Berkowitz:

Okay, so one last question about that. You were a doctor with clinical experience and you're an economist with statistical experience -- does that make you see economics differently than some of your colleagues?

McClellan:

I think it makes me see economics differently and also medicine a bit differently. From the economic standpoint, a lot of the people who work in health economics specialize in areas like microeconomic theory and industrial organization -- how competition works or doesn't when you don't have that many competitors and good information, and so forth, or public economics. Those are fields that I specialized in too, but I think I see things somewhat differently because I have been able to have a lot more hands-on experience with what

actually happens in hospitals and doctors' offices. When I talk to my colleagues from med school or residency or medical practice, I get to hear some first-hand accounts of what's really not working and what's really going on with various health policies that are intended to do one thing and often end up doing a lot of things quite differently. It's a hands-on approach to guiding some of my research and some of the policy work that I've done.

Conversely, economists who do applied work pretty much take as a given that they're not going to be able to do the experiment that they'd like to do. For example: if the price of rice goes up what happens to demand? It's hard to set up a market wide experiment on that question. So much of applied economics has been statistical analyses of what we might call natural experiments or other clever ways to look at things that are influencing market outcomes, giving you some variation to study. I think what's helped a lot of my applied work in medicine and health policy has been bringing the mindset that there are a lot of things that influence the way that medicine is practiced that don't have any direct relationship to the characteristics of the patients, and that can help us learn a lot about what works and what doesn't in healthcare.

Berkowitz:

So from this incredible graduate education you then got a really good job at Stanford which seems to have been both in medicine and in economics. So you changed coasts. How did that come about? Was it that just you interviewed at the American Economic Association and you got the job or?

McClellan:

It was interviews and knowing some of the people who were on the faculty there. Stanford, at that time, had a number of people who were working in health economics, including in the economics department, like Victor Fuchs in the business school, like Alain Enthoven and, actually, one of the few other M.D/Ph.D. economists around the time -- Alan Garber -- all of whom I had got gotten to know in my previous academic work for my thesis and leading up to being ready to get an academic job. Stanford also had the nice feature of the campus all being in one place. One of the downsides of life in Boston, and I really liked it there too, was MIT economics is in Cambridge. The medical school is a few miles away and kind of more south of downtown Boston --

Berkowitz:

Can you tell me what your work at Stanford was like? I have this picture of you with chalk on your coat from your economics lecture and then taking that off and putting on a white coat and looking at somebody with an arm fracture or something like that.

McClellan:

It was somewhat like that through medical school, through residency and some later.

People who do Ph.D.s in economics will tell you that one of the biggest holdups in getting an empirical project done is just getting the data together. It can take a long time. An advantage of being able to work on my medical rotations while I was also doing research is that when I sent a letter off about funding or when I sent a letter off to CMS about data, and it took them a month to get back to me, I had something to do. And, similarly, as my career went on I was able to blend some of that clinical work and the research.

I've not practiced medicine since going to the White House in 2001. There weren't a lot of patients that I could easily access that [laughs] they thought were appropriate for me to care for. But, having that kind of connection was really important in getting my research off the ground and I think in helping to keep me grounded in what actually can work in medical practice.

Berkowitz:

So when you were at Stanford you were doing clinical work?

McClellan:

Yes, alongside the research and teaching. One of the nice things about being in a major academic center like Stanford or Harvard is that there are plenty of really good medical students and residents and so, for a faculty advisor, it makes life relatively easy. You've got a really good team to work with.

Berkowitz:

One other question about Stanford then: you got tenure eventually and then you're both a professor or associate professor of economics and medicine. But medicine -- it's not quite the same structure, as I understand it, right? They don't really have tenure do they?

McClellan:

Right, and so my main tenure appointment technically was in the economics department and most of my funding and support was through economics. But, the medical school connection was something that was very easy at Stanford. It's all co-located and a number of other faculty were also doing kind of joint work between medicine and something else. They really liked the connection.

Berkowitz:

So now there is a new turn in your career. When you were at Stanford, while you were still in the tenure process, you went to Washington. And you became the deputy assistant secretary for economic policy at the Treasury in the Clinton administration?

McClellan:

That's right.

Berkowitz:

How did that come about?

McClellan:

Well, as you know, these political jobs aren't ones where there's a bulletin board and list to apply for. I was doing my usual assistant professor work at Stanford; this was around the time of the Medicare Commission. And it had not yet issued its report yet but it was fairly clear where it was headed. It was headed in the direction of, if not premium support, some pretty competitive reformation of the Medicare program. And the leadership in the Clinton administration, the president's advisors on down, saw a potentially important role for competition in the program but also, I think, they were nervous about where the recommendations might go. So the job that I took, the deputy assistant secretary position,

was one under then Secretary Bob Rubin who'd previously been in the White House where he was close to President Clinton. The Treasury Department then, in the Clinton administration under Rubin -- Rubin was secretary and Larry Summers was deputy secretary -- was prior to -- I don't want to say oversight but making sure that on any major initiative that the administration was undertaking Sec. Rubin or Deputy Sec. Summers would be involved in the policymaking. They could see that a big part of the issues coming in the next year was going to be related to healthcare, with the Medicare Commission coming up in its recommendations. Also the president, at that point, was interested in potentially pursuing some Social Security reforms, which get into the some of the same kinds of issues around older Americans and demographics and health that I had been involved in.

So, yes, pretty much I got a call out of the blue from somebody with Sec. Rubin's office, asking if I might be interested in this. Then I talked to the assistant secretary, David Wilcox, who was a terrific guy; a macroeconomist now at the fed, about the work that might be involved. Given the opportunity to have an impact on some very important issues for the future of the country -- Medicare design, maybe Social Security -- it seemed like a great job to take. Shortly after I accepted the job, the Monica Lewinsky scandal broke, and one of the lessons about getting involved in policy issues in Washington is that they usually turn out interesting but they usually don't turn out the way that you thought they would.

One of the challenges in this job was there was a political overhang going on at the same time. But, still, there was a lot of interest in coming up with a good solution going forward. I think that for the work that we subsequently did on Medicare -- and what eventually became the Medicare Advantage Program -- some of the work in the Clinton administration helped bridge the gap between where Republicans had been with premium support proposals and where Democrats were with trying to hang onto the traditional program alone.

Berkowitz:

That's very interesting. Did you ever get a job offer to go to Wall Street from Rubin?

McClellan:

No, my job with him was always intended to be a time-limited position. I wanted to go back to the job at Stanford after I was done with that and that's what I did. I was there for about a bit over a year, enough time to work on kind of a compromise alternative to premium support. One of the insights there was that you can have some of the advantages of competition, meaning beneficiaries saving money if they choose a less costly plan, but doing so in a way that didn't necessarily raise premiums for people who stayed in traditional Medicare. And some of those ideas have since been incorporated in legislation; a lot of that framework was the foundation for what became the Part D program.

Berkowitz:

I see, interesting. So this job then as the deputy assistant secretary: was it a presidential appointment?

McClellan:

It was a presidential appointment

Berkowitz:

Really?

McClellan:

Yes [laughs]

Berkowitz:

So you were first an appointee of a Democratic administration.

McClellan:

Yes, that's right.

With healthcare there are some very big and important controversial issues where the American public is divided and has different philosophical views about the role of government. Of course, where could that matter more than in healthcare? But there are still a lot of aspects to health policy where bipartisan agreement is possible. For example, we're doing this interview in late April 2015, just after a Congress that people have viewed as highly divided, has passed legislation to permanently repeal the Medicare sustainable growth rate physician payment formula; and they're working on potential bipartisan legislation around medical innovation, and medical product surveillance.

So, there are some big philosophical differences. But there are some areas of agreement around things like better information, on quality, and on potential ways to make competition work -- at least to some extent, there may be differences on the magnitude of that-- there are areas of agreement on things like reforming the way that payments in healthcare work -- to be less about volume and more about helping providers deliver better care at lower cost. I found a lot of bipartisanship, actually, throughout my career.

Berkowitz:

And thinking about opinions in these areas, it's significant that if you go out on the street here and say "How do you feel about the adjustment of the Part B payment to doctors?" Most people would not have a clue.

McClellan:

Right, but it's a \$100 billion a year program that has leverage far beyond that. I think that's another important insight that I got to see firsthand -- by practicing medicine and seeing how these payment rules really do influence what doctors can and can't do. And if you don't have the resources to practice in a new way, even if you think that it would be much better, say, to treat patients with chronic illnesses from home, via phone calls and tele-medicine services, Internet-based services now; if there's no mechanism to pay for that, it just doesn't happen as easily. And, again, these are areas where, whatever your philosophical views, I think there are opportunities for making healthcare work better.

Berkowitz:

Yes, so rules constrain behavior but often in unanticipated ways?

McClellan:

Yes.

Berkowitz:

So, at this point, this seems like a critical junction of your career. You've got tenure at Stanford. You have been in Washington, so you've tasted the water here. Do you go through a little internal dialogue that says, "Okay, I'm going to now do policy stuff. I'm not going to do the clinical medicine stuff. I'm not going to do the academic economic stuff so much." Is there something that goes on in your thinking like that?

McClellan:

A bit, but by that time a lot of the work that I was doing, I felt like, had a good research connection to policy. So, at that point, I was working on things like how changes in payment affected not only the treatment of patients but their outcomes; how medical liability rules influence care; how competition influenced the way that hospitals and doctors got together and, maybe, the way that they invested in technologies and treated patients. And then a lot of work on biomedical innovation; you can see how much of a difference new kinds of technologies could make to patients. I could see that in Medicare data over time with improving outcomes and reduced incidence of heart attacks. You could see that with cancer care and related studies of a number of other areas of clinical medicine. So, I don't know that my research fundamentally changed. I think it just kind of reinforced the importance of trying to put together the economics and the policy and impact on the health of Americans and people around the world. And, at that point too, that was the year before I got tenure, so it was a good time to get some publications out [laughs].

Berkowitz:

Great examples, all of those questions, these empirical questions you could publish on.

McClellan:

Yes. I was very lucky to be able to work at this interface between economics and health outcomes and public policy.

Berkowitz:

So let's get into the Bush years now. I know that President Bush is from Texas and lived in Austin for a while, and your mom was in the Texas state government and in Austin government. So, had you already met Governor Bush?

McClellan:

I had. I'd met Gov. Bush -- had some interactions with Gov. Bush before he was governor. My brother was in his press and communications office in the state before moving over to the campaign, and I'd had a chance to meet with then Gov. Bush and talk with him about a few healthcare issues, both before the campaign and a little bit during the campaign too.

Berkowitz:

How did that go? He strikes me as sort of a laid-back character --

McClellan:

Well, he is but he had, as a priority, in the campaign in 2000 and beyond, particularly, getting a drug benefit into Medicare and then using that opportunity to bring Medicare's

benefit structure more up-to-date to try to make Medicare into a more competitive looking program -- with more choices of plans that could provide sets of services that were not present in traditional Medicare; things like care coordination services and, in Medicaid, services that people could get at home, rather than in a nursing home; things like that.

Berkowitz:

Are you suggesting that Governor, then President Bush, thought about what became Part D even before he was president?

McClellan:

He definitely thought about Part D before he became president.

One thing that people have either liked or not liked about Governor, then President Bush, is that he was very clear about what he was going to do. He ran on six big issues in the 2000 election, including things like Social Security reform, and a tax cut. One of those big six was bringing a drug benefit into Medicare, and he was absolutely committed to trying to make that happen. In fact, that's how I ended up working with him further.

I was not very active on the campaign. I was trying to get tenure and taking a break from Washington and so forth. But, shortly after the Supreme Court reached its decision in *Bush v. Gore*, I got a call from someone from the transition team, a guy named Josh Bolton, who was heading up the domestic policy transition, asking if I could come spend a bit of time on the foreshortened transition, working on an initiative that the President could announce the day after he was inaugurated to help low-income seniors with their prescription drugs. This was kind of a forerunner of what would be the legislative proposals around a full prescription drug benefit in Medicare, since everybody expected that was going to take some time to develop and get through Congress. He wanted to do something right off the bat, since this had been one of his top campaign promises. And one thing led to another from there.

Berkowitz:

I hadn't thought about this before -- that, of course it's a foreshortened transition.

McClellan:

Any good presidential candidate is going to be doing some foundational planning for the administration so you can get off the ground on the right foot on January 2nd. But the month-plus delay in having an official start to the transition made it more difficult to do things right off the bat. So, I was commuting between my jobs; I was spending most of the weeks up here for about a month, between late December, mid-January, getting those initial proposals together.

Berkowitz:

Interesting. Do you think that on what became Part D that the former Bush president, "Bush 41," was an influence? There seems to be a lot of continuity of both the personnel and some ideas.

McClellan:

Yes, I think it was part of the overall influence. I think the way the President liked to think about it is that if we were starting in 2000, we probably wouldn't have designed Medicare the way it was. It fit the 1960s indemnity insurance model with no drug coverage. But, given that Medicare was an integral part of care for seniors, it needed to be modernized to include a drug benefit. I think some Republicans thought the additional spending there was a real budgetary concern, but I think the president's view was that it needed to be done as efficiently as possible. And it needed to be done in a way that drove more efficient healthcare. You cannot deliver good medicine without integrated, effective drug coverage. And I could see that in my medical practice, and I think that was probably a long-standing influence on the President; probably he even talked about it with his father and about the Medicare program having an integral role for seniors and trying to make sure it's done as effectively as possible.

Berkowitz:

Medicare can be a highly technical field and a particularly hard program to comprehend. At what level is the president engaging in this? Is he at the macro policy level or is he...?

McClellan:

He made sure that the strategic direction was where he wanted to go and he had a very strong staff around him in the White House, including strategic advisors like Karl Rove, including his economic policy team, which included Josh Bolton and other people like Larry Lindsey, who headed the National Economic Council. I was part of that group; kind of the economic advisory team. Our job was to make sure that we came up with effective proposals: effective from a technical standpoint; effective from a political standpoint; and effective, most importantly, from fitting with his philosophical view about where the Medicare program ought to go.

The President was definitely in the mode of wanting to work with Congress to get this done. We didn't work internally on a very detailed, extensive, 500 page Medicare reform and drug benefit reform proposal. Instead, we worked on some principles that we developed with Congressional leaders, including, obviously, the Republicans but to a considerable extent, Democrats too. I had a lot of meetings with Senator (Max) Baucus and his staff, with Senator (Edward) Kennedy and his staff. The President's view was that he put out the principles and then we could work with Congress on filling in the details and rely on our ability to help make sure that those details got filled in effectively.

Berkowitz:

You may know that when John F. Kennedy was president, Ted Sorensen was one of his main people in the White House, but Ted Sorensen's brother also had a job in the State Department. Your brother also came to the administration in the very beginning?

McClellan:

That's right.

Berkowitz:

Presumably, at some point, he began to see the president every day?

McClellan:

I think he saw the president more frequently than I did. He was deputy press secretary from the beginning and eventually became press secretary. So that's closer proximity to the Oval Office than us guys who worked on the Council of Economic Advisers and the National Economic Council [laughs].

Berkowitz:

Did you talk to each other about your work?

McClellan:

We did. We talked to each other a lot. He was a bachelor in those early administration days, so was frequently over to see us for a home-cooked meal. We talked a lot and worked together a lot in the office, since Scott handled a lot of the domestic policy issues, including healthcare. But it was also good to have a perspective outside the office of being able to leave that behind but still be able to talk about it with someone whom I had been so close to my whole life.

Berkowitz:

That's very interesting. There must've been times when the White House and the agency you led, CMS or FDA, were kind of at odds with one another, which would have put you sort of at odds with your brother?

McClellan:

It could have, but remember that I started out in the administration on the White House side of things and was working pretty closely with CMS and later with FDA and other parts of HHS, as well.

One nice thing about starting out at the White House but knowing a lot of the people who are working in the departments is that it helped us build up a good working relationship. So, for example, at the start of the administration, Tom Scully was CMS administrator. He's somebody who I had known a bit from my prior work in academics. He had previously been at the Federation of American Hospitals. I had previously done a lot of studies about hospitals and what was and wasn't working and on public policy related to hospitals. We'd crossed paths while I was working in the Clinton administration. Bobby Jindal was the Assistant Secretary for Planning and Evaluation at HHS, and we had also gotten to know each other a bit during his time at the Medicare Commission and previously in the transition work. So there were areas where we needed to work out different policy perspectives but, for the most part, it was actually a pretty good working relationship. I think that's very important for getting work done in government. The White House does have the ultimate say on things, but you can get so much more done if there's an alignment, if you're working together on the key strategies and the main big things that you want to get accomplished. And I had a lot of opportunities to do that with HHS staff.

Berkowitz:

-- It shows how personal contacts are important.

McClellan:

Personal contacts matter a lot.

Berkowitz:

Let me just get back to the Council of Economic Advisers which presidents have used differently, depending on the president. And it only started in Harry Truman's time so it's not all that old.

McClellan:

Right.

Berkowitz:

How did Bush use the Council of Economic Advisers? You were actually a member of the Council. You weren't just staff.

McClellan:

Right.

Berkowitz:

Did each of you on the Council have portfolios?

McClellan:

Yeah, I actually had double duty jobs. One portfolio was the domestic microeconomics on the Council of Economic Advisers. Typically there's someone who does international, someone who does macro, and then somebody does micro. So I filled that role, and I also did health policy work and health financing work for the National Economic Council. The National Economic Council is a different staff entity in the White House that manages the policy process on economic issues. The healthcare issues considered economic issues are, basically, the ones that cost big money, in the billions; that's things like Medicare, Medicaid, and some of the other big funding programs in HHS. It was actually a nice combination because it enabled me to use more economic expertise than might normally have been the case. The Council of Economic Advisers typically works pretty closely with The National Economic Council in any administration. That's where most of the economists are, maybe with OMB as well, but that's where a lot of the economic thinking comes from. By having both of those jobs together, I think it helped me make sure that the kinds of things that the Council of Economic Advisers cares about -- good, sound economics going into policymaking -- really happened.

Berkowitz:

The next job you had in the administration was becoming the head of FDA?

McClellan:

Right.

Berkowitz:

Can you talk a little bit about the internal politics of how you got to be the head of the FDA?

McClellan:

There had been a search process going on for some time, and I think the staff that were overseeing presidential personnel had always thought about me as potentially being a fit there. As time went on, I think they thought I might be a better fit there. I'd been doing

some work on issues related to drugs and regulation in the White House and, because the position hadn't been filled and because it's such a critical position for public health, I think it was not only an important opportunity for me but a really important job to have filled by somebody who could be effective in the administration.

Berkowitz:

So what you're saying is that there are other jobs you could have done like being head of CMS but it's a matter of what's open at the time?

McClellan:

Well, it was what's open at the time, but also if you think about a dream job in the intersection of science and medicine and public policy, heading the FDA is it. The FDA is the world's biggest fire hose for everything that's happening and interesting, not just in medicine, but in food and -- really, in anything related to public health that the public cares about and impacts their lives. It was a wonderful place to work just because there's so much coming through that mattered.

I liked to tell the staff that, "Look, we're going to get criticized no matter what we do because every issue we're dealing with is something that people care about. So let's try to do the right thing and get out there and actively defend it." The FDA has its own full-time press corps. They're going to write a story every day. They might as well write it about something that is on our positive agenda. So it was a great job, both for engaging the public, and for just learning about everything going on in science and public health, and for making a difference for the public.

One of the things about FDA is that its budget is very limited, compared to the mandate that Congress has given it "to protect and promote the public health." So having some of those economics principles in mind was helpful in saying, "Look, we're very clear. We can't do everything and we're explicitly going to prioritize, given our limited resources, where we're going to have the most bang for the buck in effective regulation and in new initiatives to make regulatory processes -- things like the medical innovation process and post-market surveillance -- work better."

Berkowitz:

So this is an agency that has its main office in Rockville, right?

McClellan:

Their main offices then were in Rockville. I actually did the groundbreaking for the new integrated FDA campus that's now in White Oak, Maryland.

Berkowitz:

Is it like some other agencies where the agency is in Maryland somewhere but the person who's the head of it really has to be in Washington?

McClellan:

It's a challenge. Fortunately, Rockville is not that far from Washington so it's not too bad of a commute to spend some of the day in Rockville and of some of the day down in

Washington. But it is, like other agencies, it's one where it is important to spend some time in the Maryland office and to engage with the staff.

Berkowitz:

Did they brief you about the process of meeting with those the agency regulated, such as at a lunch?

McClellan:

I don't think I went to any of those meetings as lunches but there was definitely a well-established process for briefings on meetings and for guidance about what was appropriate and not. I have to say, I don't think that ever really was a significant issue. We tried to establish a set of principles around how we'd engage on issues. I think I took some of this from the President's leadership approach, which is to identify the big themes, try to develop them in a way that works well with the staff and the constituencies that you're engaged with, and then try to support the staff on implementing those policies.

We had five major policy themes at FDA. Number one was efficient risk management, which was basically saying "We've got a limited budget, we're going to make it go as far as possible," and then trying to have some quantitative backing for what were and what weren't going to be our priorities. It gave me a chance to tell Congress or critics that "Look, this is all the resources we have. This is why we're putting them here and not putting them there."

The other thing I think is very important for the staff is for them to know that they can focus on doing a professional job. There are all kinds of political pressures at FDA. A lot of people say the agency is risk averse. They want, for example, to approve a new drug or allow a new product on the market, but fear that something might go wrong and it'll get hauled up before Congress. I think one of the most important jobs of the commissioner is - as the public face -- to be the heat shield for the agency. So anytime there was an oversight hearing or a "60 Minutes" story on something the agency was allegedly doing wrong, I tried to make a point of being out there for that.

Berkowitz:

Did you read a lot about thalidomide?

McClellan:

Some about that case and others -- the span of the agency is very broad. I was there for the first case of mad cow disease in the United States and the regulatory response for that. I was there for implementation of a new round of steps to try to make the drug development process more efficient. I was there for new steps on food safety and food imports which were becoming more internationally based. They have become even more internationally based since then. We're going toward international markets for food, food sourcing and so forth.

Berkowitz:

Let me talk to you now about CMS which is one of our main subjects here today. I was curious about your move -- what's the background story behind that. I was also curious about the difference in culture. FDA is a real science organization. CMS is different.

McClellan:

Yes it is. CMS comes from a different history and has a different culture that grew up with it.

The big determinant for me moving over there was passage of the Medicare Modernization Act, one of the President's top priorities. I had worked with him a lot before going to the FDA and with the White House staff and HHS and others -- the Hill, legislators, interest groups and others -- on getting that law developed and then passed. Its implementation was going to be a real challenge and was a real priority for the President. I think, but for that, I would have stayed at FDA a good deal longer and been very happy there. And, you're right that it is a different culture.

CMS -- and previously HCFA -- grew out of the Social Security Administration, which was, first and foremost, about paying benefits and then claims accurately and on time. In the case of CMS it was even more complicated than SSA. There are 10,000 different Part B prices, hundreds of DRGs; there are complex post-acute care payments; there are thousands and thousands of medical providers all over the country and beneficiaries depending on them. So a lot of attention has to go to making that infrastructure work well, given, as always, limited government resources to do it effectively.

Berkowitz:

That was top priority when you got to CMS?

McClellan:

Well, that was top priority but remember that the President supported the drug benefit as did a lot of other backers in Congress, not just Republicans, because they viewed it as a way to modernize the program -- to make Medicare more about delivering modern support for keeping people healthy and more effective ways of delivering medical services than had been the case in the past. The drug benefit was the leading edge of that. That was the most obvious and glaring hole in Medicare's benefit structure. It's an integral part of medicine, an integral part of preventing complications from chronic diseases or even from them developing in the first place and it was not in Medicare.

But that same problem was true in many other aspects of health care such as tele-medicine and team-based approaches to care. But on the Medicaid side too, just as Medicare was based on 1965 statute about indemnity benefits for hospital and physician services, Medicaid was based on a 1965 statute where, for long-term care, there was an entitlement to care for eligible people but that mainly entitled them to going into a nursing home. By 2000, 2002, 2004, going to a nursing home was just not the way many people wanted to get their Medicaid benefits. They wanted to be in the community. They wanted to be at home.

So I went into the agency very much aware that while the drug benefit was the lead issue that everybody was focusing on, politically and otherwise, this was really just the lead of, potentially, a lot of opportunities to change the way that Medicare and Medicaid approach care. And this predated me. We were not the first ones to try to implement new kinds of Medicaid waivers. When I was at the White House we tried to do a number of things to

promote new ways of delivering long-term services and supports. Similarly, on Medicare, CMS had tried a number of pilot programs for reforming payments, to make them more about better results over cost and less about paying for specific services.

I did want to go back to one story from my early days in the administration. This is actually just after I started at the Council of Economic Advisers, spring of 2001, pre-9/11, back when the security right next to the White House was nothing like what it is today, I got a call from the Chief of Staff: "Mark, I want you to go down to the corner of 17th and Pennsylvania-- in front of the executive office building -- and do something about the protesters who are blocking the intersection." I'm like, "Well, that's not part of my job. Andy, I'm the Council of Economic Advisers guy." He's like "Yeah, get down there" [laughs].

So I went down there. It turned out to be a group called ADAPT (a grass roots disability rights group). It was people like Bob Kafka and Bruce Darling -- people with disabilities who often depend on Medicaid for their long-term services and supports. They were there to advocate for being able to get their Medicaid benefits in the way that they preferred. Many of them came from states where they had an entitlement to get their care through a nursing home, but not through home care. And, after spending some time with them -- this is coming up on rush hour in the rain -- I was listening and thinking "Well, this all makes sense. Yes, well, why can't you do that?"

So I called up the OMB director, Mitch Daniels, who came down and we subsequently met with them and that led to an administration initiative, with budget priority behind it, thanks to working with Mitch at OMB for Money Follows the Person. That program is basically taking this principle of whatever works best for a person is what should be paid for in our healthcare entitlements. It shouldn't be structured around just specific lines of services that aren't keeping up with modern medicine. And the same thing was true for implementing the drug benefit in Medicare.

My first talk when I became Medicare administrator -- I wanted to make sure my first speech was to the staff. It was an internal meeting at our offices up in Baltimore and I led off by saying that "You are the nation's largest public health agency." Some in the crowd were thinking "McClellan doesn't know he's not at FDA anymore," meaning that CMS is under the Social Security Act, not under the Public Health Service Act as is FDA. I meant that the way that we pay for care has probably a bigger impact on anything else in the way care is delivered and has a fundamental impact the way that people -- ranging from Medicaid beneficiaries with disabilities to seniors with chronic illnesses and need prescription drugs -- get care.

It's been a long process since then, as Medicare's moved from an agency that still has to pay the bills accurately and on time, to one that puts a significant and growing amount of emphasis on its role in promoting and protecting the public health. But I think that's really changed over the last decade at the agency. It had started before I got there. But the drug benefit and some of the changes in payment policy -- like implementing early versions of accountable care organizations and so forth which didn't get as much attention as the drug benefit, but were a key part of my tenure there -- were part of that process of turning CMS

into an agency that's not just about paying the bills but about promoting the health of the public.

Berkowitz:

We're near the end of our hour. I think that's probably a good note on which to end Thank you.

McClellan:

Thank you.

Interview with Michael McMullan

By telephone on May 26, 2015

Interview conducted by Edward Berkowitz

Transcript edited for clarity.

Berkowitz:

Today is May 26th, the day after Memorial Day, and I'm talking with Michael McMullan over the telephone. You are in Washington?

McMullan:

No, I live in Baltimore.

Berkowitz:

All right. I'm actually in Baltimore, as well. So, I'm talking across town to Michael McMullan. Let me ask you, I'm just curious, and I'm sure other people have asked you about this. How did you come by that name? Is that just an Irish name?

McMullan:

My mother liked it. She had decided on it before I was born. She liked the alliteration.

Berkowitz:

Do people call you Michael?

McMullan:

Yes, they do.

Berkowitz:

I'd like to ask you a bit about your life and your career at CMS and maybe a bit about healthcare issues. Let's start by talking about your background. Where did you grow up?

McMullan:

I grew up mainly on the West Coast. I lived a number of different places because of the nature of my father's work. We lived mainly between California and Washington State; I also lived in Wyoming, Kansas, Massachusetts, and North Dakota.

Berkowitz:

What was your father's job that he had to move around so much?

McMullan:

He was involved in large-scale construction, e.g., railroad tunnels, and dams. He did the contracting at the beginning of the work. Later in his career he moved into the aerospace industry. We moved back to the East Coast with that transition.

My father was a Virginian, and he liked the idea of being closer to his home state. My mother had been in Washington, D.C. during World War II and really liked the East Coast. So we ended up on the East Coast.

Berkowitz:

I know that you got to CMS around 1973; what happened just before that?

McMullan:

I graduated from Washington College, and after college, I worked at the Federal Reserve Board of Governors as a research assistant. While I really enjoyed it there, they were not a particularly progressive employer at the time. I had heard that Social Security was a more progressive employer. I applied for a position working in what was then called the Division of Direct Reimbursement.

Berkowitz:

Wasn't that something that was set up as an alternative fiscal intermediary for hospitals under Medicare? Some of them could use it? Is that the idea?

McMullan:

Right. The statute allowed organizations to choose to use the federal government as their fiscal intermediary or carrier; it was mostly municipals and federal hospitals that did so. But there were others.

Berkowitz:

So, you went to work at SSA, but you worked on Medicare from the beginning? You worked in Woodlawn, I assume?

McMullan:

I did. We were in the East Building on the Social Security Administration campus.

Berkowitz:

What was your entry-level job?

McMullan:

I was a methods and procedures analyst.

We were responsible for operationalizing policy. For example, a policy would come out on payments or review criteria; we needed to make it work, so that providers could get paid and the money was accounted for.

Berkowitz:

I know that SSA was a very large organization and is a very large organization, but when you first got there, was Robert Ball still there or had he left?

McMullan:

I don't believe he was still there.

Berkowitz:

Did you ever get to meet Arthur Hess?

McMullan:

At an awards ceremony but not personally.

Berkowitz:

So, you had a whole career basically at what became HCFA and then CMS.

Maybe you could talk a bit about the actual founding of HCFA, what that looked like from your point of view in the organization.

McMullan:

Medicare was merged with the Medicaid function from SRS, the Social and Rehabilitative Services Administration. Medicare is a very complicated but organized and stable program. Essentially, there are one set of rules. Medicaid is a different program for every state. The SRS program did not the same amount of structure that Medicare program had when the programs were merged.

The Medicaid people staff came into the world of Medicare which had the larger presence. People who came in, like in any merger, felt as if they were not as well attuned to what was going on in the organization that they joined. At the time, I was in an organization responsible for data analysis and program statistics, we incorporated part of the Medicaid function with the Medicare function, it was a struggle of cultures.

At the highest level, the systems, the social and health insurance principles, Medicare and Medicaid are the same. They are very different programs in the way they're administered; they are very different in the way they're financed. It was not an easy marriage.

Berkowitz:

When HCFA started, did you still see yourself as a member of the Bureau of Health Insurance? Did your identity change? You talk about working with Medicaid. Obviously, it was different, but did you feel like this was really a different agency?

McMullan:

Did I feel like it was a different agency? Those of us who came out of the Bureau of Health Insurance didn't feel as big a disruption as the people who came out of the Social and Rehabilitative Services. I think it was a much bigger change for them.

Berkowitz:

I've studied SSA employees a little bit, and the ones that became toward the top of the agency often had a crucial job that got them visibility or somehow served to advance their career. Was there a particular job like that for you at CMS?

McMullan:

My principal roles were in positions where we were trying to make a new program work, where we needed to interpret the policy and put it into operation and engage the stakeholders. As a result, I was in programs that were visible to the administration; new programs often get more visibility than the stable, mature programs.

Berkowitz:

When you got there, the end-stage renal disease and expansion of Medicare to disability beneficiaries was well in place?

McMullan:

It was in place, but I wouldn't say it was well in place. The ESRD program took a while to get well established.

After doing the methods and procedures job, I went into an organization that was responsible for the end-stage renal disease program. My job was to work with NIH to implement the medical information system that was called for in the statute.

Berkowitz:

How about the expansion to disability, maybe a little bit easier?

McMullan:

A bit easier because once someone was entitled to Medicare because of their disability, the rules that apply were more like the rules that existed in the Medicare program for the 65 and older population. For ESRD, the eligibility rules were different, the patterns of care were different and there were additional requirements in the statute to gather medical information to support ongoing understanding of the population and their patterns of care. When the program started, there were many fewer people getting dialysis. With Medicare coverage, the population expanded significantly. Medicare eligibility is based on the need for dialysis; the market responded and dialysis became more readily available because of the coverage.

Berkowitz:

You talked about other initiatives that were new things that you worked on. Do you remember what they were?

McMullan:

One of the programs I was involved in was what had been called the Peer Review Program. When I was asked to take that position, we were transitioning away from medical review to health care quality improvement. I think the QIO (Quality Improvement Organizations) Program, as it is now called, is in its twelfth scope of work. It was in the fourth scope of work where we transitioned from medical review to health care quality improvement. That was a major change for the organization. Quality was no longer being inspected after the fact. The QIOs became responsible for helping the entities within their jurisdiction to improve the quality of care for people with Medicare. Moving from medical review to health care quality improvement was a significant transition from one style of doing business to another.

When the Balanced Budget Act (BBA) was passed, I was responsible for what became known as the National Medicare Education Program. Prior to the MMA, Medicare did not routinely provide beneficiaries with information about coverage, benefits, and their rights, e.g. appeals. The BBA required a broad program to help people with Medicare understand their health insurance and their rights and protections. We created the *Medicare & You*

handbook; we instituted the 1-800-MEDICARE help line, we implemented Medicare.gov; and we created partnerships with advocacy organizations and other stakeholders to represent the population being served and so they could help people with Medicare understand their choices, benefits, and protections.

Berkowitz:

That's a lot of very visible things, as you say. Could you tell me a little bit more about the peer review program? When I think of peer review, I think of it as something done by the hospital itself to look at its own work. But --

McMullan:

The peer review program is called for in Title XI of the Social Security Act; it requires state-based organizations to review the quality of care provided to people with Medicare. Under the original statute, the organizations had to be physician-based. Some of them were state medical societies. Others were organizations led by physicians. The original approach was largely focused on the retrospective review of medical records. Peer Review Organizations would review -- randomly or based on a complaint -- medical records to see if the quality of care delivered was appropriate and met the local standards of care.

Berkowitz:

It sounds like a consumer organization agency rather than just a cost control organization?

McMullan:

It wasn't meant to control cost. It was meant to manage or help ensure the quality of care to people with Medicare.

When I joined the program, Don Berwick was at the Institute for Healthcare Improvement. He was one of the main voices talking about the need to change from "inspectors" inspecting care to a focus on learning and improving the quality of health care delivery. During the transition from peer review to the QIO program, Don Berwick, and others at the Institute, consulted with HCFA to design the transition to health care quality improvement.

The change came out of the philosophy of Deming and others who believed in iterative cycles of continuous improvement; the plan do study act cycle. IHI helped us with training and conceptualizing a program to bring best practices and evidence-based medicine to health care institutions and providers through the state based Quality Improvement Organizations.

There is still is the requirement under the statute to do quality reviews on a complaint basis. Recently, CMS changed the QIO contracts. Some of the Quality Improvement Organizations perform the program's case review and monitoring activities others focus on the quality improvement activities.

Berkowitz:

Quality improvement work like this -- it seems to me that there'd be a lot of resistance on the part of providers, who could see the downside of this but have a harder time seeing the upside of it. Did you find that to be true? Is that fair?

McMullan:

The challenge was the clinicians needed to hear its value from a trusted source -- principally other clinicians. I think this is still the case.

The government has other levers for change. The government has the payment lever and regulatory levers.

Berkowitz:

You also talked about this whole effort to open up the program with Medicare.gov and a phone number that you can call and a handbook that you can look at. Could you talk a bit about the implementation of that? You must've seen the whole web thing come into existence. It certainly didn't exist when you started in 1978.

McMullan:

It was a very new concept, and the government is hard to change. For example, we had to struggle to get approval to have the website called Medicare.gov because the standard was an agency-oriented approach like "CMS.HHS.gov."

The whole idea in the statute was to make Medicare accessible, to make information about Medicare accessible to the public. We were able to persuade the people that needed to be persuaded that we needed to have a name for the website that would be intuitive to the target audience; but it wasn't immediately apparent to everyone.

Nancy Ann DeParle was Administrator and Donna Shalala was the Secretary of HHS at the time, and they each were very good advocates. When we would take issues that needed to be resolved up to their levels, they each understood the importance of making the information meaningful to the people that were being served, not just the people who understood the economics or the policy aspects of program changes. It was a big transition. The people in the government had been used to writing rules and writing instructions for providers; writing in language that is plain and clear to the public was a big transition. And [laughs] Medicare policy is not always easy to explain.

It was an interesting time to be at CMS.

Berkowitz:

Let me ask you another question about that, if I might. Let's say I live in New Jersey, and I'm a Medicare beneficiary. I get a lot of letters from the local Medicare organization that is handling my bills. And to me, I would think that would be Medicare rather than the national government. Does that question make sense?

McMullan:

Oh, it absolutely does make sense because it was not unusual -- it wasn't frequent but it wasn't unusual for us to hear people say "Keep the government out of my Medicare."

Berkowitz:

[laughs] Right.

McMullan:

People don't always understand that it is a government run program. If you're in Maryland, you're getting a summary of benefits from Care First. If you are in a Medicare Advantage Plan, you identify with whatever the plan is, whether it's Aetna or Humana or United, since those organization are where the beneficiary as the member are getting the most of their information about services and payments.

By contrast, the Medicare handbook, which is mailed by the government annually, is more of a reference document.

Berkowitz:

That's a bit of a culture change, to have people think about the national program. Let me ask you too about another aspect of this. A lot of the elderly don't have computers and the phone is very important in getting information. You talked about that number -- the central number you could call to get Medicare information. I would imagine, many of the questions would be, "I got this bill, and I think Medicare should be reimbursing this and you're not" and so on. Are the people who answer the phone at 1-800-Medicare able to handle questions at the individual level about the health care bills or is it intended for some different purpose?

McMullan:

It's not. The original reason called for in the law was to make information available so people with Medicare were aware of their coverage, benefits, rights and protections and their option to stay in fee for service Medicare or to join a Medicare Advantage plan, then called Medicare + Choice.

1-800-Medicare staff answer questions about what's covered, what the benefits are, are they eligible to enroll in a Medicare Advantage Plan, what plans are available in their area, prescription drug coverage and what plans are available.

1-800-Medicare staff can provide basic information about claims status, deductive status, and plan enrollment.

The contractors that pay Medicare fee-for service claims and the Medicare Advantage plans provide summary of benefits or an explanation of benefits, which includes a number to call about the specifics of a claim.

Berkowitz:

Would one of the callers be somebody who says, "Next year I'm going to go on Medicare, how do I start?"

McMullan:

They would be able to answer the basic question and tell them that when you are 65, you're eligible and they would give them the number of the Social Security Office or refer them to the SSA website. Social Security remains responsible for enrolling people in Medicare. Once they're enrolled, CMS is responsible for the administration of the Medicare benefits.

Berkowitz:

Is that an arrangement that's worked out well, in your opinion?

McMullan:

Medicare is a child of Social Security so it's been a long-standing relationship, SSA and CMS have built significant systems over the 50 years to make sure that programs work well together.

It would be good to someone on the Social Security side for their perspective. For example, I think that Social Security was less enthusiastic about becoming responsible for the Low Income Subsidy determination under Part D. At the same time, I believe they have always seen it as their role to be the ones to enroll individuals into Medicare.

Berkowitz:

Right. And of course there's an anomaly that comes after 1983 in that the ages are not exactly aligned. You could be eligible for Medicare at 65, and for me, for example, my basic year of eligibility for Social Security would be when I'm 66, which seems to me also creates problems that didn't exist in 1965.

McMullan:

It does, because many people who continue to work don't understand that they have to actively enroll in Medicare Part A if they're yet not getting a Social Security benefit. .

Berkowitz:

So let me ask you also one other question about the phones, which I find interesting. Do the people who answer the information hotline phones have scripts?

McMullan:

Yes. In order to help make sure that a caller gets a reliable answer to a question, there was an effort to put in place scripts that were based out of the same plain language as the handbook and other Medicare publications. When 1-800 began, scripts were put in place as well as a mechanism to accumulate data as to what questions were being asked most frequently so that additional scripts could be written.

I-800 also uses an approach where the calls were tiered. The simple calls and even some of the next level calls are able to be scripted, and then -- if the caller has a question that cannot be answered by a script, they are referred to someone who is more expert in the program and could either answer the person's question or understand what the question is, research it, and get back to the individual. The majority of questions can be answered based on scripts.

Before setting up 1-800-Medicare, we made a number of benchmarking visits. One of the places that we went was an insurer for people who are in the armed services -- USAA (United Services Automobile Association). They used scripts and call-tiering; and they had very high customer satisfaction.

We also went to a few other locations to see how they were managing the way they answered the calls, the way they recruited their call center operators, how they had the ability to monitor the call volume, how they had the ability to listen in and make sure that

the calls were being answered correctly. We learned from those visits and set up our contracts based on the best practices we observed.

Berkowitz:

If I were to call this call center, the person I'm speaking to is a contractee, not an employee of CMS?

McMullan:

Yes. CMS has about 5,000 employees nationwide and they do business through probably 15 times that many people, for support services like the call center, with States for Medicaid and the Children's Health Insurance Program, Medicare Administrative Contractors to pay fee service claims, health plans to administer benefits for people joining Medicare Advantage and Part D plans, etc. The vast majority of the operations for the programs that CMS administers are contracted.

Berkowitz:

And of course, when I call my cable company or try to get an answer about a computer, I often reach people that are not in this country, at all. But I assume, in your case, that this operation is totally domiciled in the United States?

McMullan:

It is and has been from the beginning.

Berkowitz:

Was that an issue? Did Congress make an issue of this?

McMullan:

It was always the arrangement from the beginning. At the beginning of the program I testified in front of the Government Affairs Committee. One of the first questions I was asked was if the call center was in the U.S. and if the staff were native English or native Spanish speakers?

Berkowitz:

At the end of the Clinton Administration and the beginning of the Bush 43 Administration, you were in charge of running the agency for a bit. Is that correct?

McMullan:

Yes.

Berkowitz:

How did that come about? What were the dynamics there?

McMullan:

Mike Hash and Bob Berenson were both at the agency at that time. When Bush won, they asked me if I would consider being the Acting Administrator.

Berkowitz:

So, it was down to that level as opposed to the President or the Secretary or something like that?

McMullan:

Yes. They may have talked to the Secretary, prior to asking me; but I was asked by Bob and Mike.

Berkowitz:

Were you there during the period of time when it was unclear who'd win the election, or was the election already decided by the time you took the job?

McMullan:

I became the Acting Administrator when the Administration changed.

Berkowitz:

What did you understand your job to be in the role of Acting Administrator?

McMullan:

To be the face of CMS to the Department and to the Congress and to make sure that programs and the Agency kept functioning the way that it needed to function. I was responsible for making sure that the claims were being paid, that the Medicaid state plans were being reviewed, that the states were getting the information that they needed, that policy decisions were being vetted, and the policies and the regulations were getting done on time. I responded to the higher level Congressional inquiries. And I helped with the transition to the next administration and briefing them and making sure that they had the information they needed to understand what they were becoming involved in.

Berkowitz:

That was going to be one of my questions. So you had meetings then with the transition team from the Bush Administration?

McMullan:

Yes. And I met with the Secretary who had weekly meetings with all of the Agency heads so that he could express his interests and discuss his ideas and ask for any input from the collected group. We also routinely met with the transition team to ensure they had the information they needed. I carried information back to my HCFA colleagues, engaged them in the issues and meetings.

Berkowitz:

So, when you meet with someone like that -- and I think it'd be common to a lot of things that you did -- you work a lot with political appointees in the agency and in the department and elsewhere and in this case, with the transition people. These people are obviously political, but you're not. You're not a political person, at all. So, do you think about that? Do you, for example, try to anticipate what these folks are going to be interested in? I don't know, maybe they're going to be interested in the drug benefit? Or do you sort of try to be just as absolutely neutral as you possibly can be?

McMullan:

The job of a career executive is to help each Administration do the work that they've come to do, to maintain the ongoing work and to implement whatever the new initiatives are, as long as they are within the statutory authority of the Agency. Fortunately for me, we had a very strong group of federal staff who helped work on the transition.

From the career side, the job included putting together background information that would be the most useful to the new group coming in. We used this information to brief them on all of the programs and their status, the rules that were in play and any state issues that were in play. We are very well-prepared for the new administration, and for Tom Scully who was the nominee for the Administrator. He and I worked together for a month to six weeks while I was still the Acting Administrator.

We also supported efforts that Tom was working on behalf of the Secretary and others in the Administration he was advising at that time. Building relationships -- new relationships -- was also part of the job -- introducing him to the people who would be reporting to him, and helping introduce the new political layer to the career staff.

Berkowitz:

You talked about Tom Scully, and I was just curious, whether from your vantage point from all those years in the agency, there is a template for being the Administrator. Are there particular skills that seem relevant to this job which make some people able to do it better than others?

McMullan:

I think -- in addition to being very bright -- it is a passion for what you believe in. The best Administrators I worked with cared about what they were trying to accomplish. They were passionate about wanting to make it happen.

Berkowitz:

So Tom Scully or Gail Wilensky or Bruce Vladeck, were those people that fit your concept of passionate about the job?

McMullan:

All of them did; yes. They each cared about what they were there to do, and were committed to doing it in a way that it would work from the perspective that they were representing.

Berkowitz:

I've not heard many complaints from people who've said, "Well a lot of the bureaucrats, a lot of the people working at CMS, they didn't really believe in Medicare and choice," let's say. "They preferred the traditional Medicare model." You hear that very seldom. Instead you hear that when the law is passed, "We'll implement the law." Is that a fair assessment?

McMullan:

You asked about what make a good Administrator. What makes a good career executive is the ability to do what the public chooses. The public elects the government officials. In their elections, the public chooses a certain approach. Their minds change. The administrations and the Congress change. You're asked to do different things. There is a

standard, as long as it's legal and ethical and moral, you're there to provide your best advice and counsel to the political leadership and to execute the will of the public. That's what public service is.

Berkowitz:

Let's talk a bit about that next administration -- the Bush 43 administration, where you seemed to have a lot of key roles in those years. You served as Director for Beneficiary Services in the Center for Beneficiary Choices. Do I have that right?

McMullan:

Yes.

Berkowitz:

Can you tell me a bit about that? What was involved with that job?

McMullan:

That was when Medicare + Choice was changed to Medicare Advantage. There was a bigger emphasis on helping people understand their opportunity to enroll in an HMO (health maintenance organization) or a PPO (preferred provider organization). We working through all the mechanisms that we had, the plans themselves, all of the different communication channels that we talked earlier, the telephone, the website, the publications, to help beneficiaries understand their opportunities to enroll in a Medicare Advantage plans. I worked with both the consumer advocates and health plans to make sure that the choices beneficiaries had were explained appropriately so that they could make an informed choice. I also worked closely with colleagues responsible for implementing the Medical Advantage program on the health plan side to make sure that our approaches and our communications were consistent.

Berkowitz:

After passage of the Medicare Modernization Act, were you involved at all in the drug program involved in Part D?

McMullan:

I was; Part D was my last major program operational implementation before I retired.

Berkowitz:

Do you have any interesting stories about that? We've been told that that was a particularly successful implementation.

McMullan:

I believe it was. It wasn't easy and it wasn't flawless, but it was successful. People were able to enroll in drug plans. They were able to get their drugs from the pharmacy. There were mechanisms put in place to make sure that people who were eligible for the low income subsidy got the subsidies. It was successful from the point of view of making sure that people had access to the benefit and to information and support services to help them make an informed choice.

The program has been criticized for having too much choice -- too many drug plans. The right balance of the number of plans is a hard thing to determine a priori. You have to let the market find its "right" level.

Because of the number of plans the criticism was the choice was overwhelming for the beneficiaries. Our experience from the Medicare Advantage program was that people make judgments based on price, loyalty to their physician, plan name recognition and in the how the coverage met their personal needs. We used this knowledge to help design programs to educate the public about their options and the programs and materials that were available to help them.

I believe the program was well-executed -- within the agency; everyone was integrated into one operational unit, making it happen.

Berkowitz:

What led to your decision to leave the CMS? Did you just reach retirement age and decide to leave or was there a decision there?

McMullan:

I enjoyed every job I ever had at CMS. I enjoyed it because the work was interesting and it was meaningful. You felt as if you were making a contribution to the lives of people who were getting the benefits that you were helping to administer. It was very satisfying from that point of view.

At least at the level that I was at the end of my career, it was a very stressful environment. People who had retired before me told me that I would know when I was ready to retire, and I did.

Berkowitz:

I have one final question for you, but I wanted to ask, first, a question that I haven't asked anybody else. You were there when they built that fancy headquarters in Woodlawn. I was just wondering -- did that improve morale, to have that new big building?

McMullan:

Well, it's interesting. It gave an opportunity, at least for the first several years, for people to be in one place.

With the creation of HCFA, staff were located in lots of different buildings for a long time, and there wasn't a true sense of community. Being together in a single place created a better sense of community and common purpose. You weren't as isolated from your colleagues which was good.

Berkowitz:

My last question is this: when you think about these programs that you spent your career working with, Medicare and Medicaid, what's going to happen in the future with them? Where are we going to go with them?

McMullan:

Medicare is the backbone for healthcare for the elderly and the disabled, and it will continue to be that.

Medicaid is more complicated. It now has 20 percent more people in it than in Medicare, and it's likely to grow. How do we make sure Medicaid works effectively for all of the people who are enrolled; how do we afford the growth in the program, how do we make sure that States design programs that meet the needs of their citizens?

Medicare is very complicated, but it's one program. Medicaid is also complicated, and it's over 50 different programs. I think the future of Medicaid is more challenging.

Berkowitz:

Very good. Thank you so much for doing this interview. We really appreciate it.

McMullan:

My pleasure. Thank you.

Interview with Leslie Norwalk

Washington DC on April 21, 2015

Interview conducted by Edward Berkowitz

Transcript edited for clarity.

Berkowitz:

Today is April 21st and I am in Washington, D.C. with Leslie Norwalk.

I'd like to begin with some questions about your background. All of the things that I've read about you mention the fact that you grew up in Oakwood Ohio.

Norwalk:

That is correct. I grew up in Oakwood, along with several other political appointees, some of who have been under the gun more recently of late.

Berkowitz:

And Oakwood is the place where one of the Wright brothers had a house.

Norwalk:

That is correct, two blocks from where I grew up.

Berkowitz:

Has that had an influence on your career? Are you an Ohioan?

Norwalk:

I am clearly an Ohioan, although many people think I'm from Connecticut for whatever reason -- perhaps because of Norwalk, Connecticut; but I'm a Midwestern girl through and through.

Berkowitz:

And you went to Wellesley after that -- Class of 1988?

Norwalk:

Correct.

Berkowitz:

That was somewhat unusual. You could have gone to Miami of Ohio or something like that.

Norwalk:

I could have, but it was way too close to home. [laughs] The goal was to get away, not to stay. As much as I liked growing up in Oakwood, it's a very homogenous population, and I wanted to get out and explore more things. And I had spent my childhood going to girls' camps, and the thought of a single-sex education was one that appealed to me, and it was exactly as I thought it would be; it was a fantastic experience.

Berkowitz:

Your high school, I assume, was coed?

Norwalk:

Oh yes, absolutely. And I spent a year of college at St. Andrews in Scotland, which was also coed.

Berkowitz:

I see. And in college you majored international relations and economics?

Norwalk:

Correct. At that point I had no interest in domestic policy whatsoever. I thought healthcare was boring. I thought domestic policy boring. I find the whole thing highly ironic as to where I ended up.

Berkowitz:

So were your studies in economics about foreign trade -- that kind of international policies?

Norwalk:

A little bit but my economics major was more pure economics. I did my thesis on the economic impact of military spending in the U.S., the Soviet Union, and Japan. The one way that is similar to healthcare, of course, is the issue about the burden of military spending on our society versus the burden on the Japanese who spend so little compared to us.

Today, consider the huge burden Medicare, Medicaid, and Social Security have on the president's budget now and into the future. It is the issue that we will need to tackle as a country going forward -- mandatory spending relative to any other spending and the related questions: do you raise taxes? Do you reform how the programs are run because of this? We think about it but not seriously enough given the issue that it will become or already is.

Berkowitz:

You graduated in 1988 which was a political year. It was election year. But your interests seem to be international as opposed to domestic.

Norwalk:

They were, correct.

Berkowitz:

So were you political at all?

Norwalk:

I wasn't political in college, however I suspect I didn't get the investment banking job I so desperately wanted partly because of the crash of 1987 which was right in the middle of the interview process and influenced the number of jobs being offered. So I ended up moving to Washington. My uncle has a company here. I worked for my uncle over the summer and worked for George H. W. Bush's campaign, so I became political after college.

Berkowitz:

How did that happen?

Norwalk:

A friend of mine from Wellesley was working on the Dukakis campaign, and I said, "Oh, I'd like to do some political campaigning but Michael Dukakis is not my guy." She said, "Well a good friend of mine, also from Wellesley who graduated a year ahead of us, is working for the Bush campaign in research. You should meet her. Why don't you go down and I'll introduce you." That's exactly what happened, and Peggy Dooley, which was her name, got me involved in the campaign doing more than stuffing envelopes which was a bonus when you're right out of college.

Berkowitz:

And in that campaign did they send you somewhere, or did you stay here in Washington?

Norwalk:

I was here in Washington, at headquarters.

Berkowitz:

You were doing central office kind of stuff?

Norwalk:

Yes. I was doing research. Shortly after I came on board, the President selected Dan Quayle as the VP candidate and a lot of people, including people on the campaign, didn't know much about him. So it was my job in part, with lots of other people, to figure out what were his positions -- to figure out who was Dan Quayle and what was he all about.

Berkowitz:

So George, the first George Bush whom you call "41" as he was the forty-first president -- from what I can tell, he is a very nice guy.

Norwalk:

He's fabulous.

Berkowitz:

Did you actually meet him personally?

Norwalk:

I did meet him because after the campaign I ended up working in his White House. I did meet him but very cursorily. He was coming down the stairs, I was going up the stairs, for example, and I was thinking, "Oh my, there's the president with the Secret Service." He's saying, "Oh, I'm sorry I was in your way." I'm thinking, "I'm pretty sure it's the other way around." He's an exceptionally gracious human being, very gracious. The more I know about him, the more I like him and I'm sorry that I was of an age where I couldn't have had more responsibility and been able to interact with him more often when I was at the White House, but I was 23 --

Berkowitz:

But you got a job in the White House which is very desirable --

Norwalk:

I did. That was pretty good. It beat working on Wall Street, I have to say.

Berkowitz:

So you were working in the personnel office, right?

Norwalk:

I was working in Presidential Personnel, which is the office which does the political hiring for the departments; it is separate and apart from White House hiring.

Berkowitz:

I see. That's pretty important. Who was the head of that office?

Norwalk:

At the time, Chase Untermeyer ran the office and then when he left, Jan Naylor became the head of the office; but Chase Untermeyer was the head most of the time I was there.

Berkowitz:

And was your appointment political?

Norwalk:

Yes.

Berkowitz:

Even at that level?

Norwalk:

Absolutely; most of the White House jobs are political.

Berkowitz:

So you had an office in this brick, red brick --

Norwalk:

No, that's the new executive building. I was in the old executive office building, now the Eisenhower Executive Office Building but yes, that's where our office was.

Berkowitz:

And later on you went to work for the Trade Representative?

Norwalk:

I did. I worked for one of the deputies when I got tired of interviewing people, which I did for two-and-a-half years. I left and because of my interest in international trade, I went to work for the Deputy Trade Representative named Ambassador Mike Moscow who was in charge of the trade agreements with China, Japan, as opposed to say the EU, which

another deputy handled. And he also negotiated a few specific topics -- steel, Airbus -- so we had some very specific issues as well. It was interesting, but I was bored.

Berkowitz:

I see. He had one of those offices that are sort of near the White House?

Norwalk:

Yes, on the other side of the old executive office building across from the White House; there's a really pretty building where there are probably 180 people that work at USTR.

Berkowitz:

I see. So at some point you decide to go to law school. What's the sequence there?

Norwalk:

I was bored at USTR and I also saw the writing on the wall that as much as I liked 41, he was unlikely to be reelected. And therefore, because I was bored and I didn't think he'd be reelected, I decided that I should go to law school at night which would give me something to do in the likely event that he was not reelected. And that's exactly what happened. So I started going to law school in the fall of 1992 and I went at night and a semester later I was still going to law school but I was not working at USTR after January 20th.

Berkowitz:

So you became a full-time law student at that point?

Norwalk:

No, I didn't. I continued to go to law school at night and in maybe May of 1993 I started working as a paralegal at Epstein, Becker, and Green which is a law firm that happens to do healthcare. It was the job that I found. I didn't find a whole lot of work after the administration ended so when I ended up at Epstein Becker, I learned about healthcare. And I found the healthcare field actually was really interesting; before then, I just was oblivious to how interesting it would be.

Berkowitz:

Right; it has a lot of economics in it.

Norwalk:

Yes.

Berkowitz:

Not much international trade.

Norwalk:

No. I did almost no international work, which I think is very interesting on the one hand but, on the other hand, healthcare, in large part because of Medicare, but certainly Medicaid as well, is quite complex. Health insurance generally can be complicated. I found it fascinating, which is a good thing.

Berkowitz:

So these people you would be working with in the law firm, would they be focused on regulatory law? Did the clients have issues with some branch of the government that's dealing with healthcare?

Norwalk:

Typically. Epstein Becker at the time was one of the biggest, and remains one of the biggest, firms in the corporate legal healthcare space. When I first started there in 1993, some people said "Oh, you do healthcare law, is that ambulance chasing?" I'd say, "No, no, it's corporate," which is to say we practice law in many areas -- everything such as tax, antitrust, and corporate compliance -- which is often Medicare specific. I probably did every state survey related to health insurance known to man. What are the rules around utilization review in every state? What licensure do you need to have in order to pay claims and be a third party administrator? Is there a corporate practice of medicine prohibition? You name it. If there was a 50-state survey, I probably worked on it and helped clients figure out what they needed -- where there were compliance obligations.

Berkowitz:

So it sounds to me like you got a good background from that in the nitty gritty of health policy.

Norwalk:

I did and as it happened, once I got out of the 50-state survey phase and particularly as I started practicing after I passed the Bar in 1996, I had a lot of clients that were Medicare + Choice or Medicare risk plans, for example. I served as general counsel to a couple of Coventry plans that had a broader array of products but they were HMOs. I also did a lot of work for a company called Fallon Community Health Plan that offered everything from a PACE program to Medicare risk and now Medicare Advantage plans, Medicaid managed care -- it had all the government reimbursement components to it.

Berkowitz:

What does "PACE program" mean?

Norwalk:

PACE (Program for All Inclusive Care) is a program that CMS has that in order to qualify you need to have Medicare Part A and Part B, or Medicaid. You can be as young as 55, so it's 55 and over, and it's intended to cover care in the community and be a replacement option for those needing nursing home care. To be a PACE program, you have to provide an opportunity and a location for people to come to you on a daily basis. It's sort of adult daycare, but with all the other services that you would get from Medicare and Medicaid. It was started by On Lok in San Francisco and Jennie Chen Hansen, who you may know from when she was chair of AARP, was the -- I don't know if she was the first president -- but when I was at CMS she was the president of On Lok. It's a great program.

Berkowitz:

I see. Alright. So now we get to the center of our discussion here, which is CMS, which I guess was actually called CMS by the time you got there.

Norwalk:

Just -- Scully had just changed it maybe within two months of me joining. I can't remember exactly when he did it but he did it the Fall of 2001 and I joined in November of 2001.

Berkowitz:

So I'm curious about this world of the Bushes a little bit. So 43 is now in office, right? That's the president in this case. I'm interested in the continuity between those two Bush administrations. Did you find that once you're in the family network, you're in the family network? Or was the Bush 43 crowd completely different from the Bush 41 crowd?

Norwalk:

I think it depends. I have a pretty good idea of how a lot of this works from having spent time in Presidential Personnel. And when I was there, one of the departments I handled was Health and Human Services, which is sort of how I ended up in the 43 administration. Someone who was working in Presidential Personnel for 43 had been at HCFA under 41, and so we sort of switched. His name was Ed Moy. He ran the Office of Managed Care for 41 within HCFA and then for 43 he was one of the top people in Presidential Personnel. In a sense, he knew me from my prior service to 41 and I also worked with his wife who came to Presidential Personnel. In that regard, it is a little bit of who you know. I didn't work with (Tom) Scully at all. Scully had no idea who I was in the 41 administration and initially had no interest in working with me under 43, which is very funny.

Berkowitz:

Did you know at that time that with a new administration, new opportunity, CMS is one of the places you wanted to be as opposed to some other part of government?

Norwalk:

Well I actually had no interest in going back into the administration. My law practice was going just fine. I was probably going to be a partner in a couple of years and I get this call from my friend at the White House who said, "Leslie, are you interested in going back in and if you are, what might you be interested in?" I said, "No, not really," but he said, "Well will you come talk to us?" I said something like, "Well I'm happy to come talk to you but I have nothing in particular in mind." It's not like I was going to qualify for Supreme Court justice or anything [laughs].

Berkowitz:

Not yet, anyway.

Norwalk:

This is true [laughs]. But I did know that pretty much all the work that I had done interacting with the federal government would have been related to CMS as opposed to HHS.

Berkowitz:

I guess you mean not being considered for the Office of the Secretary in this case.

Norwalk:

The Secretary or any other division. There are lots of divisions: FDA, NIH, ASPE, CDC. It's a big place. I wasn't interested other than in CMS. Years later, now, I really feel that

way. It's almost like, "Oh, don't you want to go back and be Secretary? No, I have no interest in being Secretary or any other position in any administration."

Berkowitz:

Really?

Norwalk:

Yes, really.

Berkowitz:

Interesting. So if Jeb Bush gets to be president, you'd say thank you but --

Norwalk:

I'm happy to serve on a committee that does not require a full-time job. I think Jeb is terrific, and he actually offered me a job to work at AHCA (Florida Agency for Health Care Administration), which is the Florida CMS, if you will, except that I had to decide whether I was going to stay and work on the drug benefit or move to Florida, and D.C. won over Tallahassee. I think he's terrific. But no, I --

Berkowitz:

That's interesting because some people would say to be a cabinet officer, that would be the apex of my life, but you don't feel that way.

Norwalk:

No, [laughs], that's not me. I have the greatest life ever. I have no interest in changing it. I just want to continue to do what I'm doing as long as I humanly possibly can.

Berkowitz:

That's excellent. That's a great attitude.

Norwalk:

I'm very fortunate.

Berkowitz:

So you get to CMS and you had a lot of different jobs there at a lot of levels at CMS.

Norwalk:

No good deed goes unpunished [laughs].

Berkowitz:

I wonder if you could take us through that part of your career just a little bit and also talk some about the people like (Tom) Scully and (Mark) McClellan who were working with you.

Norwalk:

Sure. When I got to CMS in November 2001, my job was counselor to the administrator, whatever that meant -- no one could really define it for me. They just knew that a lot of work was required, and Scully was sure he would find something for me to do, although, as I said before, I don't think he was all that interested in having me work for him. The White

House wanted me to work at CMS, and he wasn't all that interested in having someone who the White House wanted. He wasn't sure that was going to work for him, and the White House goal, I think, was to see if they could keep Tom out of trouble. Have you talked to Tom already?

Berkowitz:

Not yet but we will.

Norwalk:

I love him. He's fabulous, but that was the goal and Tom, of course, wanted none of it. Ultimately, he changed his mind and when I came over, in spite of the fact that no one could tell me what the job really was, I had a goal of doing what I could to learn from the career staff and to try and solve problems that otherwise seemed intractable, but couldn't get to the level of the deputy administrator or the administrator. Typically those problems were cross-silo problems.

Medicare and Medicaid were generally silos, and problems often arose between them. Of course, now they have a whole office for dual eligibles, but there were plenty of problems I dealt with that, even with this office, it would be very difficult to find one person to resolve. The CMS staff couldn't figure it out among themselves because they had other jobs to do typically, and they couldn't get anyone to make a decision. So I would help shepherd that process. That was my goal which went fairly well.

Not long after I arrived, the number three person, a woman named Linda Fishman who was the senior policy advisor, left, and so I got her responsibilities. It was very ad hoc. That's how Tom -- well maybe it's actually how the front office generally works. You sort of do whatever is needed, and you never know what's going to be needed. It depends on legislation.

Berkowitz:

On one hand you have these programs going on every day, Medicare and Medicaid, et cetera. On the other hand, there's --

Norwalk:

All these other things that are happening and you never know what's going to be required. Then, Ruben King-Shaw was the deputy and chief operating officer, and not long after Linda left, Ruben started to spend four days a week at the Treasury Department working on HSAs (health savings accounts); one day a week is not all that much time at CMS. So I started helping with the sorts of things that he would have otherwise been doing. I can't remember when but at some point in time then, we would have more and more discussions around the drug benefit and how that was going -- what that would look like from a policy perspective, long before it ever got to Capitol Hill. Fairly early on I started going to meetings at the White House about policy decisions.

Berkowitz:

Were these meetings about the policy with regard to actually implementing a drug benefit, how the agency going was going to handle this?

Norwalk:

No, earlier on it was much more about what the drug benefit should look like. What are the actuaries saying? Do you have to have a donut hole? What do you do about a deductible? What do you do about re-insurance? As it happened, I wrote re-insurance policies at Epstein Becker before I went to CMS. Who knew that that would be relevant to my future career? You never know. It's all very funny. We were asking things like do you allow tiering in a formulary? How many plans should be offered? What would a government Fallback plan look like? Should it be mandatory for beneficiaries? Do you opt in? Do you opt out? What do you do about Medicaid? We wrestled with all sorts of issues.

That probably would have started in, at some point in 2002, but in addition, it wasn't just that. It was anything else policy driven that was relevant from a Medicare perspective; fee-for-service generally was also an issue. If we were talking about the physician fee schedule, or inpatient hospital payments, or psych services, or who knows, whatever it was, we would, in our weekly meetings, discuss whatever issue came up depending on where we were in the calendar year.

Berkowitz:

Those issues sound very political actually.

Norwalk:

Yes, absolutely. They are issues that are "political" with a small p, at least in my mind. They concern lots of differing interests that may have nothing to do with being a Democrat or Republican but more with how you make your money. Are you going to pay me more or less and what are you going to do for my competition and so on?

You're constantly being lobbied from people on the outside to do x, y, or z. So when you're coming together to try and figure out some of the daily things, you're also trying to think about broader things. The train is running in terms of the regulations which must come out on time and so forth, but what else do you do in terms of making policy? For example, what should we do about dual eligibles? Medigap insurance was something that came up in this timeframe that was passed in the Medicare Modernization Act that wasn't something that we had to do but it was something desirable from a policy perspective. If we think first dollar coverage is problematic for spending, for example, then how might we restructure a couple of other plans that could be sold on the market in addition to A through J, for example.

Berkowitz:

I see, interesting. So just to go back for a second, you used the word actuary at one point and that caught my ear because I know that there was a lot of publicity about the relationship between the agency and the actuary trying to figure out what something is going to cost -- which is inherently an unknowable thing.

Norwalk:

Correct.

Berkowitz:

Was that something that was peripheral to you?

Norwalk:

No. Not only was it not peripheral, I had to testify in front of Congress on April Fools' Day, maybe it was in 2004. Scully had left. It was the first time I testified. I've testified several times since, but it was the first time I had the privilege of testifying in front of a full Ways and Means Committee of however many, 45 people sitting up there grilling into me.

Berkowitz:

The whole committee?

Norwalk:

Oh, the whole committee. Not the subcommittee, the whole committee. Yes, let's just say I'm quite familiar with what was going on.

It's a very interesting thing. The statute gives the office of the actuary, in a way, independence, on the one hand, to theoretically be free from political pressure as to what something might cost. At the time, this whole issue was over the score of the Medicare Modernization Act. And of course, by 2004 when I testified, it had already passed. But the actuary determines scorekeeping for the executive branch whereas the Congressional Budget Office determines scorekeeping for Congress and what bills may cost into the future. The CBO includes more than actuaries, although the Office of the Actuary will typically have other disciplines in it as well. In any event, the scores were \$155 billion apart.

Berkowitz:

That sounds to me like a significant amount of money.

Norwalk:

Correct. Interestingly, estimates of the cost of the Balanced Budget Act similarly were \$100-some billion dollars apart. It's not all that unusual that they be far apart. The point is, CBO and the Office of the Actuary keep score for different people and the concern was that this difference had somehow been suppressed, that we weren't telling Congress what we thought the drug benefit was going to cost. Well, first of all, Congress has its own scorekeepers. What the actuaries feel is somewhat irrelevant to what Congress does because that doesn't count for their scorekeeping in the first instance. However, we did tell them.

There's that whole newspaper article that came out before the law passed in September. I think the *Wall Street Journal* put it out about how they were over \$100 billion apart. It wasn't really this big secret. I'm thinking, "Well, here's a newspaper article that, in fact, says no secret." It was a whole lot about little. But, I think the point is there is an inherent tension. You saw it last week when the current actuary Paul Spitalnic -- Rick Foster has retired -- came out with something on the cost of the sustainable growth rate, a part of physician reimbursement, different from what CBO thought.

I'm fairly certain there are other times when the actuaries feel that it's important for them to put out information to the public or to the Hill about what something is going to cost and it

may well be that the people for whom they work disagree. I had many disagreements with the actuaries' projections on all sorts of things and I typically would just bet a dinner that estimate would turn out to be a mistake because it was a lot easier than testifying before Congress. I'm fairly certain that I'm owed more than one steak dinner, truth be told.

But to be fair, it's a very difficult job and a lot of it depends on your assumptions and my assumptions and their assumptions, not just mine, but anyone's assumptions can quite reasonably differ. And of course, as it happens with the drug benefit, both the actuaries and the Congressional Budget Office were way off, way off. Too high, both of them. It came in well under \$400 billion in that 10-year window of 2004 to 2013. It was well under - a couple hundred billion under.

Berkowitz:

It's also an historical thing that goes on in that particular agency but this actuary predates the Congressional Budget Office, and used to think of themselves as a joint employee of the Social Security Administration and the Finance Committee or the Ways and Means.

Norwalk:

That's interesting. That makes sense.

Berkowitz:

It is interesting that you didn't talk about OMB in that context. I'm assuming they would also have a dog in the fight about the cost of the drug benefit.

Norwalk:

Yes, but they have to rely on the actuary even if they disagree. Typically what would happen for me if the actuary came in and said, "This regulation is going to cost X," and I didn't think the actuary had it right, I had a way of dealing with that. While I couldn't challenge the actuary's number, the administrator has the ability to implement something over several years. So I couldn't challenge the number, but we could implement the regulation, or whatever, over several years to lessen the impact until we figured out that the real effect or Congress could change something or can use better numbers or whatever it happens to be.

So if the Office of Management of Budget or the administrator thinks the actuary estimate doesn't look right, there is often flexibility in terms of how you implement your regulations. The actuaries have a huge role at CMS, a huge role, in almost every regulation. The other way that it comes up is budgetary savings.

Every year in doing the president's budget -- you're doing three of them at any given time - the actuaries play a role in what's something going to cost in the future. If you're going to change a regulation, they estimate the cost or the savings. You can try and debate with them, question whether or not their assumptions are correct, but quite often you're stuck with whatever it is that they say. Most of the time they do a pretty good job, but they're not perfect either. No one's perfect. So it can be a challenge when, for example, you think for sure some change is going to save money. The same thing happens on the CBO side. Something looks like it would save a lot of money, and the analysts come back saying "No savings."

Berkowitz:

Yes. So you worked with Tom Scully, and you worked with Mark McClellan.

Norwalk:

I did.

Berkowitz:

And Tom Scully is a lawyer like you are.

Norwalk:

He is.

Berkowitz:

I don't know if that caused any problems --

Norwalk:

[laughs] Not really. As I said, Tom wasn't all that interested in hiring me to begin with. Once I got in there and rolled up my sleeves, I think we did a really good job of highlighting his skill sets and having me backfill where he just couldn't be everywhere all the time.

Particularly in 2003 when he spent a significant amount of time on Capitol Hill with Tommy Thompson, particularly in the fall before the drug coverage law was passed, we didn't see a lot of him, but the trains needed to continue to run, decisions needed to continue to be made. At that point I had been there a year-and-a-half and was working on the regulations and all the things where he may not have been able to participate in meetings making policy decisions. That was a lot of what I did. I would fill him in on the things where I knew that he was going to care a great deal. We did a good job of tag teaming in terms of getting things accomplished.

Berkowitz:

Were you more the Baltimore person then?

Norwalk:

It depended on the time. At some point I became the deputy and chief operating officer, and then after the drug benefit passed, we hired a different COO to help take some off my plate and do all the operational things, making sure that the drug benefit worked operationally. Also at one point when I was deputy, I also ran the Center for Beneficiary Choices, which oversaw Medicare Advantage and the drug benefit.

Berkowitz:

That's a lot of stuff.

Norwalk:

I had a lot of stuff at any given time. I did union negotiations before the drug benefit passed, and then CMS had a really big role in the Katrina response. In New Orleans, people didn't know who to call if they were a healthcare facility. They didn't have anyone else in the federal government and they called Medicare to say "We need ice" or whatever.

Berkowitz:

Because Medicare is their link to the federal government?

Norwalk:

Exactly. So we found ourselves in the middle of all sorts of things. Whatever it is, you deal with it. How can you help the people? Then, how can you help the city come back? What laws can you waive? What can you do in terms of a Medicaid demonstration? What can you do as a Medicare demonstration? You never know what will come up any given day, but working with Tom, I think we did a really good job, particularly when he was away, in making sure things didn't fall through the cracks.

Berkowitz:

So, when we get to Dr. McClellan, Mark McClellan --

Norwalk:

He's also terrific.

Berkowitz:

Yes, he's got a very high reputation. But he's a medical doctor. He's other things, but he's a medical doctor.

Norwalk:

He's all sorts of other things, yes.

Berkowitz:

Does it change your perspective as you look at CMS if you're a medical doctor?

Norwalk:

A little bit. CMS oversees Medicare coding, coverage, and payment. Certainly coverage is more a medical decision. CMS has a medical director without regard to who the administrator is. But Mark could play a bigger role in coverage decisions, particularly if he had an interest; he could ask different questions than I would know how to ask, for example. I think that can make a difference. There are a few things on the reimbursement side where there can be a need for medical background, whether that's asking someone within CMS or using NIH or whomever. It can be helpful to have a physician there. Mark's job per se wasn't really all that different. His interests were different from Tom's interests and so were the sorts of things that really excited him; for example, Mark really wanted to focus on some of the quality things.

Berkowitz:

Do you mean he wanted to focus on the practice of medicine within Medicare?

Norwalk:

A little bit, and the IOM report "To Err Is Human" had come out a few years earlier, and was still a hot topic. He was interested in really focusing on reducing errors, and moving beyond what Tom had started with nursing home quality and the web-based comparison tool Nursing Home Compare and then Hospital Compare and getting that quality

information out. Mark really wanted to help bring it to the next level, and with his background he was certainly the right person to do that. I think his FDA background was as relevant as his medical background.

Mark's interests and Tom's differed. Tom's focus and what he's really good at is lobbying. He's such a good lobbyist.

Berkowitz:

Tom's more political then?

Norwalk:

Yes. And he's a smart guy. He's exceptionally charming. He did lobby before. That's what he did before, heading the Federation of American Hospitals. But he'd spent a lot of time working Capitol Hill through his whole career. He's made to do it, and I think that without Tom Scully, we probably would not have had a drug benefit. I think of him a lot -- I personally give him a lot of credit for it.

He would not be the guy to implement it, and he would probably tell you that. Implementation is maybe less interesting to him and not exactly his skill set. Mark is more -- had a better temperament to do that -- take a new benefit and make sure that it worked right.

I loved working with Tom. I've never had so much fun. He's just hilarious. We also worked very well together. Mark and I worked very well together too, but in a very different way. I did a lot of the same things under both as deputy in terms of the policy development and negotiating with the Office of Management and Budget, and the White House, and ASPE, and the Office of General Counsel, and so on and so forth.

One of the challenges that anyone has, whether you're an administrator or deputy or whoever plays this role, is that CMS is the middle of everything because the programs there like Medicare are such a large part of the nation's budget; everyone wants a piece of the decisions about those programs. So every single day when you go to a meeting, you're the one person who's constantly putting forth your opinion about various decisions saying, "This is what I think." It's human nature that no one wants to let you win every single time. That's never going to happen. So I tried to figure out which policies we needed to really work and to develop persuasive arguments at various levels. At CMS we've got 4,000 fabulous staffers, so many would have really helped develop a particular policy and I would think: "They're right and therefore, I want to represent their opinion really well in this circle." When I say "my opinion," I really mean CMS' position.

I knew that human nature would never let me or anyone in my position "win" every policy argument, so I would think: "What's the best way to develop this policy? Who can I get as my ally for issue A?" My allies for issue A were unlikely to be my allies for issue B, who would be different for issue C. I'd try to figure out how I could tamp down the concerns of someone around issue A and if maybe I could, for example, enlist the General Counsel's or (the Office of) Legislative Affairs's help in getting someone to not be concerned. So that's what I did a lot of the time: learning the issues well enough to debate them and help bring the best resources to advance policies that were well thought out.

Berkowitz:

I see. It sounds to me like this: we all know that there are a lot of interests involved in medical stuff, medical care -- there are people who make medical devices or people that do this or that. All of them have a particular interest in various decisions. But you're pointing out that there's also this internal departmental, bureaucratic point of view --

Norwalk:

Absolutely.

Berkowitz:

-- that there's the CMS point of view, which is different from the point of view of others such as the Office of Management and Budget.

Norwalk:

It can be like that. Sometimes they all align and that's easy, but that's not why you go to those meetings. You go to those meetings because the issues that come up at those meetings are where there are different perspectives. Again, political small p, but it could be that some member of Congress is being lobbied by someone in his or her district to do something in particular and Legislative Affairs is concerned about that; but someone at CMS thinks that the interest group's perspective just doesn't make any sense and here are the three reasons why. In this case the issue might be difficult from the CMS side from a Public Affairs perspective, so you might have Legislative Affairs and Public Affairs thinking one way, but elsewhere in CMS there is a concern about the precedent a particular decision would set with staff saying "Oh, that doesn't really work." Or you might have some in CMS saying, "This is the greatest policy ever, but it's going to cost money and OMB is just going to say no, and the budget people at HHS are going to agree." Sometimes there might be different legal interpretations. Every issue has elements -- it's not uncommon at all -- where you'll have changing seats at the table as to who cares about it.

Berkowitz:

So there are different perspectives at the table for various decisions, and yet in any administration there are certain ideas that are driving people. Some people think, for example, that electronic records are the salvation of the medical system. Other people think that quality control is. That seems to be an important idea of the Bush administration, this idea of quality. I was wondering if you could articulate that for me. Is this the idea? If I know that provider A kills half their patients and provider B kills a quarter of their patients, once I know that I'm likely to go to provider B and the money should go there too. Is that the idea?

Norwalk:

I think that there are lots of different ideas and issues in this area involving quality. First you have to be able to measure it. So when you start with quality, you're starting typically with objective performance metrics. Are you giving an aspirin to every patient who presents with X, for example? Then you get to things related to quality that may be more subjective. Then there are different approaches to what might be required; differences between bricks and mortar matters and figuring out better processes for what do you do if

you're a physician, which may be somewhat more challenging. And when you get to physician quality matters, the questions get into what do you do from a specialty specific basis.

So at CMS, at least when I was there and this is probably more Tom's side, the goal is to pay in some way for quality, maybe ultimately 100 percent, but we'll start slower in large part because that's what the statute requires, but if we can at least get started by having the collection of quality data, whether it be subjective or objective, performance metrics or otherwise.

The whole area of performance metrics is challenging. If you're thinking about how you treat a patient, maybe half your patients die because you're a hospice provider and you have to have a prognosis of six months or less in order to qualify for hospice services on Medicare. Well then if you only have half your patients die, what's going on? Is that a good thing or a bad thing?

With hospice, ultimately if you're admitting the proper patients, most of them will, in fact, not survive because that's who you're treating. However, if you're a basic internist who has a regular patient population and half of them die, well that's a problem. Unless maybe you specialize and maybe you're in infectious disease and you are a specialist in Ebola, and 50 percent is great. So how do you risk adjust for the patient population that someone is treating?

A lot of that work is going to the medical societies and getting them to help us rather than us dictating what good quality is. If you're a cardiologist, what does the ACC (American College of Cardiology) say about cardiac treatment? What would the appropriate quality metrics be? The work is to have them help us figure that out. If it has the blessing of the professional societies to begin with, it's much easier politically.

Berkowitz:

I see. There are a lot of different things going on. You can say it's about providing a data set that somebody can use.

Norwalk:

Yes.

Berkowitz:

You could say it's about having Medicare only send people to the right place to get the right amount of the right treatment.

Norwalk:

Well, the Medicare program requires freedom of choice. So by statute, a beneficiary is entitled to see any physician he or she wants and therefore, unless that were to change, the most that we can do is provide information so that a patient or beneficiary or beneficiary's family can choose more wisely. That's, I think, the goal.

Then, of course, if you pay for quality, you get what you pay for. I'm a firm believer in this. The more you pay for quality, the more likely you are to get it. The more likely physicians

and other providers, facility-based providers, are to care. If you want to ding hospitals for readmissions, if the ding is big enough, you'll see fewer of them.

Berkowitz:

I see. It's complicated.

Leslie Norwalk:

Yes. Welcome to Medicare.

Berkowitz:

You're doing Medicare but you're also doing American medicine more generally, because it's going to affect the whole system?

Norwalk:

Absolutely. For example, in order to provide services to the Medicare program you need to be certified and most commercial insurers won't pay you unless you are certified by the state or by the Medicare program.

Berkowitz:

I see. Now let's talk about the time when you became the acting administrator of CMS. That was in October 2006 if I have the month correct.

Norwalk:

Correct. That is my recollection.

Berkowitz:

And you stay until August of 2007, the end of the summer.

Norwalk:

That's about right.

Berkowitz:

So can you tell me a little bit about that? Somebody must have made that decision maybe, I don't know, in the White House or at HHS.

Norwalk:

It's White House decision. Well, both actually, it's between the secretary and the White House. But yes.

It's so funny, I smile because Mark McClellan told me, he said, "This job is a lot harder than you think," and I had been there for five years. I'd been around. I'd watched a couple of administrators. I thought I had a pretty good idea. He was so right. It is so much harder than you can possibly imagine, even when you watch it day in and day out.

And I knew quite a bit going into the job of acting administrator; so one would have thought I wouldn't have been surprised by how hard the job is. I'm the sort of person who -- I roll up my sleeves, I learn the material. So I knew a fair amount but boy, the volume of what is required of the administrator is mind boggling. People talk about drinking out of a fire

hose; that would have been a day in the park. It is much more like trying to drink out of a tsunami. It is a tough, tough job.

But yes, my appointment -- that was a White House decision. I'd spent a lot of time working with folks at the White House too, separate and apart from them wanting me to be there to begin with Scully.

Berkowitz:

Did they make the decision that you were hired as the acting administrator?

Norwalk:

Yes.

Berkowitz:

Which is a decision, right? They could have said no, we're going to have so and so come in and be the administrator?

Norwalk:

Well, you can see what happened to Don Berwick.

Berkowitz:

Right.

Norwalk:

I think their choice is to try and figure out what is it that we want to do and what did I want to do? I was really sick the last -- I don't remember how long -- I had bronchitis for nearly nine months, doing both Katrina recovery and implementing the Drug Benefit. It was horrible. As much as I would have liked to stay, six years was maybe, well definitely, long enough. Somebody was asking me something like, "Don't you want to go back and do it again?" I'm like "No, I have no interest doing it again. Once was good."

Berkowitz:

Now let me pursue this just a minute, what it is to be an acting administrator. So you're the acting administrator of CMS and you're in a room with the head of the NIH and the head of the CDC and the head of other agencies at HHS, do people say, "Oh, no, you're just acting"?

Norwalk:

No. They couldn't care less. Well first of all, I'd been there for years. I was traveling around the country in 2004 and 2005 on a plane with Elias Zerhouni, head of NIH and Julie Gerberding, head of CDC. That's how I got to know McClellan. No, it must have been 2003 because that's how Mark and I became friends. I told him, "Oh please come over and run CMS when Tom leaves, please, please." I begged him. Apparently I'm relatively convincing, or else the president asked him and it had nothing to do with me [laughs].

I think what matters -- whether you're acting or not -- is whether you're a political appointee and the White House counts on you. Generally I think Kerry Weems who became acting administrator later would say the same thing -- it's totally irrelevant whether you're acting or

a confirmed administrator. You act as the administrator. I think I got a break maybe the first time I testified before Congress because I was acting although that never happened again.

Berkowitz:

In the sense that they said --

Norwalk:

Oh, you're only acting. They were very nice, and then it became readily apparent that I wasn't clueless and I no longer got the benefit of the doubt, because then the Democrats came in and I testified often. They hauled me up there all the time.

Berkowitz:

You don't think it was a gender thing?

Norwalk:

At the beginning, I do think it was a gender thing. When I testified before -- on April 1, 2004, when I testified on the whole actuary issue -- I was under the distinct impression that they thought that the other person -- there was a special assistant in the office who testified with me, a guy named Jeff Flick and he was Tom's special assistant. And my impression was that several thought Jeff was the deputy and I was Tom's assistant; it was readily apparent from the questions that they asked him. Fine with me; poor Jeff got the heat. But eventually that went away. "Oh, this young woman couldn't possibly be the deputy." was sort of the sense that I got. I wasn't complaining.

Berkowitz:

You know, I spoke to Dan Rostenkowski once and he talked about his relationship with the first lady, and it was very much a gender thing. He'd think, "Let me take care of you, madam. Leave it to me, I'll take care of the Ways and Means Committee for you," which wouldn't have been the case if it was a man.

Norwalk:

Well, yes, it could be a gender thing. Bill Thomas, in that particular hearing, was terrific. Pete Stark's wife was a year behind me at Wellesley, and Pete Stark and I also got along fine. But it might be more than a gender thing. I mean, I'm from Ohio. You asked me before if it mattered. I'm a very straight shooter, so I think generally members appreciate that.

I think the frustration was before I was the administrator, it had been a Republican Congress and Democrats had been shut out. So once they took the house back in 2007, they hauled me up there and I probably testified eight or nine times in six months. Yes, that's probably right. Once a month is a lot. To testify is to study for the Bar or whatever big exam you have, whether it's history or otherwise. It's a lot of work. I think when I testified more than once I didn't get the benefit the second time of being female. The women didn't give me any benefit at all.

Berkowitz:

Before we end, I'd like to talk a bit about more recent times and the Affordable Care Act. By the time the Affordable Care Act is being argued about and then passed and then implemented, you were a private practice lawyer again?

Norwalk:

I was and am. I have a multitude of roles. Right now I'm on seven boards of directors. I work at a law firm and I work for three private equity funds and a PR firm. So it sort depends on any given day what I'm doing. But in all instances, there is interest in the Affordable Care Act, not surprisingly. So yes, I still pay close attention to what happens.

One of the things that is very interesting about the ACA -- this is political big P -- relates to my experience with the Medicare Modernization Act. I have always found this very funny in an ironic sort of way. A lot of the material or the ideas around the prescription drug benefit for the Medicare program had been around a long time. There had been a bi-partisan commission and so on and so forth. If you look at a press release that the Clinton White House put out about their health reform plan -- with Tom Daschle in the Senate and the White House announcing it at the same time -- it describes a number of different elements about their proposed prescription drug benefit and it includes, by the way, a donut hole. It includes not interfering with the negotiations for the price of drugs. It includes any number of elements that ultimately ended up in the law that became the Medicare Modernization Act. And yet the Democrats very quickly disavowed any interest or knowledge of those approaches, saying "Oh, this is horrible. All the things that passed in the MMA, aren't these horrible?"

Fast forward to the Affordable Care Act, RomneyCare, and in fact, before RomneyCare -- by the way, I'm sure there are plenty of differences between what the Democrats were proposing and what ultimately happened and likewise, this is true between Romney Care and the Affordable Care Act. But a lot of the elements that we had discussed within the Bush administration, including RomneyCare, ended up in Bush's State of the Union address, that were similar to Obama Care in terms of having an exchange and giving individuals an opportunity to buy insurance on the exchange and to increase access to health insurance -- which is not the same as increasing health or increasing access to physicians, for example, two different things. And some of the elements, or a significant number of the elements were there before the Affordable Care Act and yet you'd think the world was coming to an end.

Now there are plenty of things that I would change about the Affordable Care Act that were different from what happened under RomneyCare, but a lot of the basic principles are still there and I just find Washington so funny. If it wasn't your idea, it's horrible. It actually could have been your idea, but if you didn't pass it, it's horrible. Let me rephrase. But it's - Washington is very funny.

Berkowitz:

I see. So you talked at the very beginning about the idea that Medicare is expensive and it doesn't leave a lot of flexibility for other things in the budget.

Norwalk:

Correct.

Berkowitz:

Would you say that's the key issue that -- politics with a small p -- that the nation is going to have to face soon?

Norwalk:

Absolutely. If you look at Medicaid, Medicaid expansion has just exploded and you don't even have every state having gone through the Affordable Care Act's Medicaid expansion, in which I imagine over time more and more states will participate.

Berkowitz:

Although there is legislation about the amount of money the federal government is going to put in.

Norwalk:

Yes, but it's a percentage, not a flat ceiling. It's very hard to say no once you've given an entitlement program, hence the word entitlement. I didn't say that these problems would be easy to solve. If you look at the numbers -- I'm not exactly sure why this is, but the CBO numbers are somewhat different from the president's budget numbers -- the budget as I recall today is roughly 18 percent Medicare, the federal portion of Medicaid is maybe another 9 percent, so it's probably 27 percent of the budget just the two of them. The component for the Affordable Care Act, the federal exchange will grow as well, but the one piece that people often don't appreciate is the interest piece and interest is now 7 percent of the budget. So if you look at just interest and Medicare and Medicaid, you're over one-third of the budget. If you add Social Security at another 20 to 21 percent, you're over half the budget.

In ten years, the interest rate, even at the current low rates we have, will be 14 percent of the budget. So between interest rates, Medicare expanding because there are 10,000 new Medicare beneficiaries a day, and Medicaid -- there are 66.7 million or so today -- and if Medicaid continues to grow, if the Affordable Care Act exchanges continue to grow, Social Security continues to grow, there's not a lot of space without raising taxes fairly significantly. There's not a lot of space to spend money on anything else.

Berkowitz:

That's a good point. Do you think that given all that it's remarkable we passed the Affordable Care Act?

Norwalk:

I think that's part of the reason that there's such concern. One concern is the level of income for a family to qualify for a subsidy for benefits under the ACA. Looking at 400 percent of the poverty level, if you're a family of four, that's roughly \$97,000.

Berkowitz:

That sounds like a lot.

Norwalk:

Yes. If you're living in a state where the cost of living isn't that high, \$97,000 can be a lot of money. Now if you're living in New York City, maybe not so much, but if you're in Iowa or even some places in Ohio, that's not a small chunk of change. So that's one area in the Affordable Care Act where I have concerns. I can appreciate why it was done, but it's still a lot. But the number of people it covers is so small. If you're only looking at 6.2 million that actually get a subsidy and only just under, whatever the number is now, 8 or 9 million, whatever it is, that are signing up, it's just dwarfed by the over 100 million that are covered by Medicare and Medicaid and growing at a rapid clip.

Berkowitz:

Right.

Norwalk:

So, this is a problem that's not going anywhere. I think generally most members, there are several members of Congress who are really smart on the topic, but I think as a general rule, it's complicated and they don't appreciate it and even if they do, it's a third rail. Social Security and Medicare are third rail politics. Great, I'll vote to cut it and I'll lose my job. That's not really working for me.

Berkowitz:

The future is not their long suit?

Norwalk:

Correct. Some are more worried about when's the next election. It's just political reality, but it's a reality that we will all be facing should we be so fortunate as to live long enough. Whether it's us or our children and grandchildren, it is a huge problem.

Berkowitz:

I think that's a good note on which to end. Thank you.

Norwalk:

Thank you.

Interview with William Roper

By telephone on April 10, 2015

Interview conducted by Edward Berkowitz

Transcript edited for clarity.

Berkowitz:

Today is April 10, 2015 and I'm talking by telephone with Dr. William Roper who, I believe, is in his office at Chapel Hill, North Carolina?

Roper:

Yes.

Berkowitz:

You may or may not remember that we've actually spoken before. The CMS commissioned a series of interviews twenty years ago of people who had worked there like yourself to establish an oral history of the agency, and you were gracious enough to do that. That interview exists in the public realm. So today's talk is a follow up.

Roper:

Okay. Good.

Berkowitz:

I'd like to discuss what you've been up to since leaving HCFA, although I want to talk a little bit about that experience as well. So, just to start, you went from being a pediatrician, who presumably sees children, to being drawn into the policy side of things. And I was just wondering if you could tell us again how you became a White House Fellow.

Roper:

Sure. So going back even into high school, I was interested in, have been interested in, leadership, management, whatever one wants to call that. I was president of the student body at my high school and college and medical school; and so when I was in medical school I learned about the broad field of public health and saw in that an opportunity to join my interests in leadership and public policy with my interest in medicine and health, and so decided to pursue a career in the broader area of public health. I did a residency in pediatrics and then for the next five years was director of the Public Health Department in Birmingham, Alabama, the urban county around Birmingham, which is my hometown.

After five years of that, I learned about and applied to the White House Fellows Program and was chosen as a fellow. I went to Washington in 1982 for a year, ended up working on the White House staff that year, and my one year in Washington stretched into being, let's see, 11 years in the federal government, most of which was in Washington, including the time at HCFA, now CMS.

Berkowitz:

Right... Might I ask you a question about President Reagan? Did you have opportunity to meet him when you were in the White House?

Roper:

Oh yes, oh yes. I was in many meetings with him. I was Special Assistant to the President for Health Policy for several years before he nominated me to the position of Administrator of the Health Care Financing Administration. So yes, I worked with him, yes.

Berkowitz:

You were in a position to take notice of the AIDS crisis then, right?

Roper:

Oh, yes. I lived through it. I was the White House's and the Reagan Administration's health policy advisor from, basically, 1982 until at least '86 when I went over to head HCFA; but throughout that period AIDS was an issue, to be sure.

Berkowitz:

Is it fair to say that President Reagan had innate interests in health care or not?

Roper:

One of the things that have been widely discussed about President Reagan and his success as a president is that he chose to be focused on a few things and to pursue them forcefully. I think it's fair to say that he was interested in a strong defense and foreign affairs and in an efficient operation of government, and lower taxes, et cetera. Health and health policy I wouldn't say was a strong personal interest of his, but I was in a number of meetings that he was present at where we discussed health issues including Medicare, Medicaid issues. So he was conversant with those things, but they were not the dominant issues for his leadership.

Berkowitz:

I see. I can't help but ask you: Is the story about Rock Hudson true? That he became aware of Rock Hudson and that kind of alerted him to AIDS more generally?

Roper:

I think that is true, yes.

Berkowitz:

I see, I see. One other Reagan question.

Roper:

Sure.

Berkowitz:

And that is, one of the ideas floating around in that period of time was this idea of changing the configuration of programs so that, for example, the federal government took over Medicaid.

Roper:

[affirmative] Yes.

Berkowitz:

Is that something you got involved in as well?

Roper:

Yes. There were many conversations through that period and since of some sort of grand bargain swap of program responsibility and funding responsibility between the federal government and the states, and I was involved in many Cabinet-level and intergovernmental discussions with the National Governors Association and leading governors, and so on. Yes, it's on its face an attractive notion. Once you get past the first paragraph, though, it's pretty complicated, and that's what people readily encounter.

Berkowitz:

Like many things, I suppose. Do you suppose President Reagan was a little more sensitive to Medicaid than Medicare because he had been a governor?

Roper:

Oh, I wouldn't say he was more focused on Medicaid than Medicare, but he surely knew about Medicaid, or Medi-Cal as it's called in California, because of his eight years as governor there, for sure.

Berkowitz:

Right. So you then got into the more formal bureaucracy of health policy, and so you said you were head of both HCFA, as it was called, and the CDC (Centers for Disease Control). I wondered -- if you might kind of compare those two.

Roper:

Sure.

Berkowitz:

-- did you feel more comfortable at CDC because it was a more academic organization as opposed to HCFA, which is a kind of mixed organization in some ways?

Roper:

I wouldn't say I was more comfortable at CDC than HCFA. I thoroughly enjoyed both times. The two agencies are different, as you say, but I experienced during the time that I headed each of them a wonderful set of activities. I have great respect for the dedicated career employees in the agencies. What I used to say to folks in an effort to compare the two is, whereas CDC is a white-hat agency, and I mean by that on a good day most people believe that what CDC is up to is good for the nation and to be celebrated, many people view the Health Care Financing Administration, now CMS, as a black-hat agency, and I used to jokingly say -- and it is a joke; please make sure you say that --

Berkowitz:

We're laughing, for the record.

Roper:

-- that on good day I made only half the people in the nation mad at me when I made decisions at HCFA.

Berkowitz:

[laughs] Right... So after that you go into the private sector for a little while --

Roper:

Yes.

Berkowitz:

-- and you worked with Prudential. Maybe you could talk about what it that got you there and how you were recruited to that job.

Roper:

Sure. So I was in Washington from the time I arrived in '82 until I went to Atlanta in the spring of 1990 to the CDC, and I was there until the summer of '93. As I jokingly put it, Bill Clinton gave me the chance to get a job in the private sector, meaning that the Clinton Administration came to office in January of '93 and I was still the director of the CDC and therefore worked under the new secretary, Donna Shalala. I got to know Donna well, still stay in touch with her. But about two months into that, in March of '93, she called me one day and said, "Bill, I hate to do this, but the White House has told me they want to put their own person in as head of CDC, so we need to talk about your departure." And I said, "I do understand. I've been expecting this phone call. All I ask is that you put out a flowery press statement about what a wonderful job I've done and what great service I've done to the nation," and she laughed, and said, "Sure. I'll be glad to do that." And she did.

And so a couple of months later, in June of '93, I left. We had a nice big party and lots of celebration by the employees of the CDC, and I stepped out of public service and went to work for Prudential Health Care. I talked to a whole bunch people about what I might do after government, ranging from pure academics, to academic leadership, to consulting, to the business world.

I had a lengthy conversation with Kaiser Permanente about going there and setting up a health services research operation inside K.P. After lots of meetings and conversations, someone that I knew inside Prudential heard about this and said, "Hey, we'd like to do that," and so they made me an offer to come to Prudential to create what became the Prudential Center for Health Care Research and gave us millions of dollars to spend to hire people and began a program of health services research.

One of the first things I did was lure away another friend of mine from the CDC, Jeffrey Koplan. Jeff came to be my number two at the Prudential Center, and especially with his skill, we recruited a number of health services researchers and then formed a broad partnership with Barbara McNeill and her colleagues at Harvard Medical School Department of Health Care Policy and undertook a whole series of studies, projects, research projects, like, for example, what's the best way to get women enrolled in an HMO to show up and have mammograms done in a routine, timely fashion? Is it better to do phone calls or postcard reminders or other means?

So anyhow, that's what the Prudential Center for Health Care Research did. After a little over a year of that, I was asked to become senior vice president for medical affairs and chief medical officer of Prudential Health Care, and Jeff Koplan, the guy I've mentioned, continued to do the health services research thing, and I oversaw that and did a number of other things for Prudential. Just to fast forward, my time at Prudential was four years, and then I got recruited to University of North Carolina to be dean of the School of Public Health. Shortly after that, Prudential sold its managed-care business to Aetna, and after a time, Aetna basically devolved the research operation to Emory University, and Jeff stayed on there where he still is at Emory. He, for a time, went back to the CDC and became director there for several years and lived through the 9/11, and anthrax, and all of that, but he's back at Emory in charge of their Global Health Program.

Berkowitz:

So Prudential -- at the time, I assume, it was interested in HMOs -- offering that as a product?

Roper:

Yes.

Berkowitz:

Was the Health Services Research division also trying to develop products that could somehow be sold to providers, or was that more for, sort of, internal advice to the company?

Roper:

We dabbled in some of them, "Could we develop products to sell?" but mostly it was internal information but also just general information for the public at large. A sizeable number of scholarly papers were published in the academic literature, the usual journals.

Berkowitz:

Were you aware of the fact that there's kind of a tradition at Prudential; that Frederick Hoffman was a famous figure in early epidemiology? Was that part of the culture at all or no?

Roper:

Don't know that story. I don't, sorry.

Berkowitz:

Were you domiciled in Newark or somewhere else?

Roper:

The health part of Prudential was in a Newark suburb called Roseland and that's where I was, but I did go to meetings in downtown Newark at the main Prudential building, yes.

Berkowitz:

I see. Can I ask you also, at that point in your life, around, say, 2004, would you have identified yourself as a Republican?

Roper:

You -- that -- to be just accurate on the calendar, I left Prudential in '97 and came to the University of North Carolina then, and so, you asked about 2004. Yeah. I've been a registered Republican since, oh, at least the late '70s, and am continuously still a Republican.

Berkowitz:

I see, okay. So let's talk a little bit about UNC and your experience there. I'm particularly interested in carryover from your HCFA/CMS days. All of a sudden you're looking at Medicare and Medicaid from a different perspective trying to run a medical school or a public health school and eventually a health care organization, right? Do Medicare and Medicaid look different to you now than they did in your HCFA days?

Roper:

I'm not sure how far-reaching you want the question to go, but --- one of the things I did at the School of Public Health was create what we call the UNC Program on Health Outcomes that sought to build on work that I had begun at HCFA in the late '80s, that is to use administrative data from the programs to undertake health services research focused on health outcomes and ultimately to guide improvements in health care. It's, I think, possible grandly to see the work that we began at HCFA in '86-'87 as the predecessor to what's now ARC and Health-Care Compare, the stuff that CMS is doing, and PCORI, the Patient Center at Outcomes Research Institute, and so on. So, yes, at UNC at the School of Public Health first and now here at the medical school we've undertaken a number of things in the health services research area.

This is to reach back a bit further but in the mid '90s I was president of what was then, let's see, the Association for Health Services Research, now Academy Health, I guess. So I've been involved, less so now, but have been involved in that field for quite a while.

Berkowitz:

The University of North Carolina has got a very prestigious Public Health School.

Roper:

Yes.

Berkowitz:

And I have this name Cecil Sheps in my mind as having been --

Roper:

Yes.

Berkowitz:

Was that a particularly socially oriented institution?

Roper:

Yes. It is highly regarded in a variety of ways. What you may be touching on, let me just comment on directly. Some people have thought it strange, even crazy, that I, having

been Ronald Reagan and George H.W. Bush's health policy advisors and a member of their administration, came to UNC School of Public Health and, in most universities the faculties are left of center, and schools of public health are even further left of center, and you're right that our school here has a number of faculty whose politics, I'm sure, are left of mine, but the seven years that I spent there as dean were very pleasant, fun, engaging. I don't think we ever had any political disputes that I can remember. So yes, it was a good time.

Berkowitz:

Right. And then you went over to the medical school.

Roper:

Yes. In 2004 I moved across the street to be dean of the School of Medicine and CEO of the Health System, which is our hospitals, and physician practices, and clinics and so on.

Berkowitz:

And those physician practices are not just in Chapel Hill, are they?

Roper:

No, we have the faculty practice here but then community-based physician practices in all parts of the state. We're about a \$3.5 billion revenue enterprise with about 2,000 hospital beds, about 2,500 physicians, so we're a health care system.

Berkowitz:

So if one of your hospitals has some sort of problem in its financing side, can you pick up the phone and call the folks in Baltimore at CMS -- say, "Hi, I'm the former administrator of the" --

Roper:

[laughs] What would I ask them?

Berkowitz:

-- and could we talk about this particular matter of adjudicating the reimbursements for Medicare," or whatever, have you?

Roper:

You know, occasionally I've had conversations with folks at CMS about particular matters, but I learned when I was there as administrator and surely, subsequently, that there's a very elaborate standard protocol for having those kinds of conversations about particular matters. They tend to begin at the Regional Office of HCFA and -- or now CMS, and, you know, it doesn't really work the way you described it, to call up and say, "We need to fix something in a particular institution." Folks are very cautious about those kind of, I think they're called by the lawyers, *ex parte* conversations.

Berkowitz:

I see. That's interesting. Can you tell me in North Carolina -- you're obviously very involved in the health scene in North Carolina. What is your mix of Medicaid patients as a percentage of your patient load?

Roper:

I don't have a number off the top of my head. It's a very large number. I think Medicare/Medicaid together probably represent -- and Tricare, nearly 50 percent of our business.

Berkowitz:

And Tricare is what?

Roper:

It's the Department of Defense health program.

Berkowitz:

I see. But more Medicaid than Medicare?

Roper:

I just don't know. I think they're about even.

Berkowitz:

I see. Let's talk a little bit about more recent events in health care policy. Obviously, one of the big milestones is the ACA, Affordable Care Act.

Roper:

Yes...

Berkowitz:

As a health policy expert with a unique background, is that something you were involved in, in the creation of?

Roper:

My good friend Nancy-Ann DeParle -- that's not a throwaway line, she and I are very good friends -- we were on the Robert Wood Johnson Foundation Board together and on a couple of corporate boards together. She was the principal architect of the ACA, although a number of other people have claimed famously to have done dramatic things for the ACA. She and I talked a number of times across the period of the design of the ACA, but I would not at all claim that I was personally responsible for any of that.

But the many features of the complicated law now known as the Affordable Care Act contain many of the elements of health reform that I worked on in the Reagan and then Bush 41 administration. I recognize fully that a number of people on the far right have described it as socialized medicine or a takeover of health care by government, and I do understand political rhetoric and how people tend to get exercised in politics, but those are just very inaccurate descriptions of the bill. I've repeatedly said in many public settings that the ACA is more complicated and more heavy-handed on government regulation than I would have done, but it's possible to see the ACA as very much in the spirit of the things that many of us worked on in the '80s and '90s.

Berkowitz:

Such as what, specifically?

Roper:

For one example -- a mandate to require everyone to be insured and to use the nation's tax system to enforce that mandate; or a modification in Medicaid to serve all poor Americans instead of just categorically eligible low-income individuals.

Berkowitz:

That all makes sense. So can you tell me how an entity like the University of North Carolina medical system prepares for a major change in the health care financing environment like the ACA? Is that something that you worked on?

Roper:

Yes, we do a number of things. We've, over the last couple of years, hired a bunch of new people to help folks who came to us to sign up for health benefits under the ACA. It's in our interest, but it's also a good thing for citizens for us to help them get eligible for and be insured under the ACA.

In another direction, one of the things that we've done to get ready and deal with it is to prepare ourselves to operate on less revenue because part of the financing of the ACA is a cut in Medicare payment rates, and so we've had to deal with the diminished revenue. Regrettably, we also thought we were going to be preparing for an expansion of Medicaid, but our state is one of the many who've chosen not to expand Medicaid yet. I say, "Yet," because I'm continuing to try to make the case to our elected officials that it's in our state's economic and health interest to expand Medicaid and maybe one of these days, one of these years, we'll get to that point.

Berkowitz:

I see. So you're very entrenched as the head of this system. I can't help but ask, are you talking with Jeb Bush on the phone about --

Roper:

[laughs] I have interacted with Governor Bush many times, but I've not talked to him since all of this, lately, has come up. I hope he is a successful candidate; we'll see what comes of that. But no, I'm not routinely chatting with Jeb these days.

Berkowitz:

All right. So now, just as a capper to our conversation, the reason we're doing these interviews is that Medicare and Medicaid are actually having their 50th anniversary this year.

Roper:

Right. Right.

Berkowitz:

And so, my question is --

Roper:

Let me just interpose to say I believe in anniversaries. One of the things I mean by that is the Health Care Financing Administration was created at the beginning of the Carter Administration in January -- February of 1977, and 10 years later, 1987, I was then the administrator of HCFA, and we had a big celebration, and our key note speaker was former Secretary of HHS Joe Califano, and we had the former administrators back, and it was a lovely event. So yes, I believe in celebrations and glad to be a part of this one.

Berkowitz:

Good, and we appreciate that. So the question people ask at these anniversaries is, "Where have we been?" but also, "Where should we go?" So in your opinion, are Medicare and Medicaid enduring parts of the health care system or not? Are they going to be changed in some way or should they --

Roper:

Oh, they have been changed many, many, many, many times, and there will continue to be those changes. I think there's absolutely no likelihood or possibility that they would be repealed or terminated. It's my fervent hope that we're going to see continued change in Medicare away from fee-for-service to what today is called Medicare Advantage. We began those programs back years ago. When I was administrator, I created the Office of Prepaid Health Care that administered the Medicare HMOs in the '80s, which have come to be Medicare Advantage, so I think we're going to continue to see movement in that direction. One of the things I'm heartened by is there are now a number of Democrats that are in favor of that. It used to be a popular Republican idea, but there were some very strident opponents, Pete Stark among them, and they've left the Congress or changed their mind.

On the Medicaid side, Medicaid suffers from being a program that has been modified so many times it is so woefully complicated. The simplification that the ACA sought to do, as I've already mentioned, to make it a program that served low-income Americans and not categorically eligible low-income Americans, is something that we simply need badly to do in a uniform way all over the country. But it suffers from the fact that it is not just a federal program but a federal and state program, and therefore we have 50-plus state-like entities dealing with it, and we've sort of reached a stalemate about the ability to do a full-scale overhaul of Medicaid. Earlier you and I were talking about this idea that's been around of some kind of grand bargain between the feds and the states around Medicaid. I don't believe that's going to happen, but we sure do need to do some things to further improve and simplify Medicaid.

Berkowitz:

That is interesting because if you had asked somebody 50 years ago about this, they would have said that Medicare was the vehicle that was going to be expanded.

Roper:

Yes, and in fact, when I was first at the White House in the early '80s, one of the things I did is go to the White House Library and pull National Journal magazines, and John Iglehart, whom you may well know, was then the health writer for the *National Journal*, and across the decade of the '70s pulled all of the health, and mostly Medicare, articles from the *National Journal*, and in the early '70s, almost all of them were about how can we go

further to add other populations to Medicare, ultimately to get to national health insurance, which, as you know, was proposed by the Nixon Administration under Cap Weinberger when he was in government. But by the middle of the 1970s there were many more articles in the *National Journal*, especially towards the end of the '70s, about the cost of the programs, and that's what led ultimately to the change in first payment of hospitals in the early '80s, payment of doctors in a different way in the late '80s, and talk of expanding Medicare was lost because of the concerns about the cost of the program.

Berkowitz:

That's interesting perspective. So I take it, when you retire, if you retire, that you're going to be served by a Medicare managed care plan?

Roper:

[laughs] I sure am. I'm 66 now, but I'm gainfully employed and look forward to that one of these days.

Berkowitz:

Oh, good. I have one final question, and that is, do you see yourself as a member of the former CMS administrator fraternity or sorority --

Roper:

Sure.

Berkowitz:

-- and do you see those folks ever?

Roper:

Oh, yes. I don't, maybe you did not know this, but we got together in, I think it was late January. Leonard Schaeffer had a dinner party at his place in Washington and all of the living, I should say, formers got together. I think there are nine of us now, starting with, Leonard was the second HCFA administrator. There were three in the Carter Administration. I was the fifth. There were two of us in the Reagan Administration, then Gail Wilensky in the Bush, and then Bruce Vladeck and Nancy-Ann DeParle in the Clinton, and then Tom Scully and Mark McClellan in Bush 43, and then Don Berwick and Marilyn Tavenner in the Obama Administration.

So all of us got together and had our picture taken, and I think it's going to be in the National Academy of Social Insurance's archives soon, if it's not there already.

Berkowitz:

That will be a nice artifact... one tangible memento from this anniversary. Dr. Roper -- thank you very much for taking the time to talk to us.

Roper:

Sure. Thank you.

Interview with Leonard D. Schaeffer

Washington, D.C. on January 28, 2015

Interviewed by Edward Berkowitz

Transcript edited for clarity.

It is followed by Mr. Schaeffer's written answers to a set of questions that were offered as examples of potential types of questions prior to the interview. Mr. Schaeffer generously sent the written answers after the interview to supplement the interview discussion.

Berkowitz:

So today is January 28 and my name's Ed Berkowitz and I'm here with Leonard Schaeffer at the National Press Club in Washington and we're going to talk about both his career and about health policy. We've also spoken before, under CMS auspices, in 1994. We concentrated then on Mr. Schaeffer's HCFA experience. You left HCFA in about 1980, right?

Schaeffer:

Yes.

Berkowitz:

And Jimmy Carter left in 1981, and you said in the previous interview that you didn't do any health care stuff after that because you felt like the lobbying laws were such that you're not supposed to be involved in that.

Schaeffer:

I didn't pursue health care opportunities immediately after working in government because the law said that you couldn't -- a person was not supposed to be in a position where they, in essence, lobbied their previous position. So I moved away from health care for a brief period of time but then came back later.

Berkowitz:

Right, right. At that point in your career, circa 1980, did you think of yourself as a health person or as an analyst, a budget analyst, or as an administrator, or what?

Schaeffer:

Well, you've touched on a point that I have thought about a lot. I'm going to leave you some material that reflects my thinking. I now teach a graduate course in leadership and management in health care. One of the points I try to make is the difference between leadership, management, and analysis. Without wasting too much of your time, they are very different skills and different people have them in different amounts. People are trained to do analysis and good analysts are highly respected. Therefore, educated people frequently mistake being a good analyst for being a manager or a leader. The issue is that analysts identify the pros and cons of a solution and come up with a recommendation.

Managers are about implementation. They use plans and budgets to get it done.

Leaders are people who inspire other people to take action to achieve their vision. Unfortunately, leadership is substance free. As you know, some of the great leaders are not such good guys. If you look at the 20th century, the great leaders that come to mind are Churchill and FDR. But Adolf Hitler was a leader too.

Berkowitz:

And Stalin, as well.

Schaeffer:

Okay, [laughs] and Stalin.

So this is a long way around to answering your initial question. I've never thought of myself as a great analyst. I think I'm fairly quick intellectually and I am able to identify good ideas from other people. As it turned out, I got big jobs very early in life and, therefore, I was not afraid to surround myself with people who were a lot smarter and a lot more experienced. So I never thought of myself as an analyst. My role was to be either a manager or a leader.

Berkowitz:

Right, but you did have the ability to read a budget statement, which not everybody can do. That turns out to be a real skill. You get to read a larger organization's budget statement.

Schaeffer:

Well, there's a big difference between being an economist and understanding what budgets are all about. Budgets are tools that managers use to get things done. That's the point of the compass that I came from.

An organization has a certain amount of money. It's associated in my mind with achieving certain goals. You have to have a lot of discipline around using that money. What are the actions that need to be taken to achieve the goal that the money was either appropriated for or earned? And are we on track to get that done? That's what managers do and that's a skill I have. But it's different from being an economist or an actuary.

Berkowitz:

Right. Let's talk a little bit about this transition from public service with HCFA to this eventual arrival in private sector health care. So you were head of Group Health in Minnesota...

Schaeffer:

Right.

Berkowitz:

And to me that connotes kind of a liberal organization, as was the Group Health Association of Washington, D.C.

Schaeffer:

Well, let's go back a bit earlier because I think you have to understand my pre-HCFA life to understand my post-HCFA jobs.

When I got out of college, I had no marketable skills, so I went to work for Arthur Andersen, which was then a highly respected accounting firm that had a consulting practice. This is the group that did the first programming of the Univac computer. So, it was a great learning experience. I was trained to program the computer and to build financial and management systems. My developing worldview was all about how to get data, turn it into information for decision-making, and then make decisions and get things done.

I also learned fairly quickly that I did not want to be a consultant, spending my time whispering in somebody else's ear. I wanted responsibility for making decisions. An opportunity came up to join the Department of Mental Health in the state of Illinois. In the beginning, the fact that it was a health care organization was not the main attraction. Rather it was that I was going to run a data processing unit, and it was a pretty big one because, back then, departments of mental health were among the largest state departments.

So I was brought in to run the IT department. I really enjoyed that but it became quite evident to me that the department was run based on past practices. The politics of that were straightforward. Most mental institutions are out in the countryside because that's where it was believed you should put mentally ill people. You don't want them around allegedly sane people.

Because they're the largest employer, these institutions become very powerful, politically. In order to maintain political power you want to have as many inpatients as you can because the more inpatients you have, the more people you employ, and the bigger your budget. So there were some patients who were institutionalized who may not have needed to be, especially after a new drug was introduced that would allow some people, previously considered schizophrenic and potentially harmful to themselves or others, to live in the community.

Berkowitz:
Thorazine?

Schaeffer:
Yes, it was Thorazine. There was resistance to deinstitutionalization for many reasons.

Berkowitz:
It makes it more remarkable that they ever did succeed with deinstitutionalization.

Schaeffer:
Well, Illinois was a leader. Now, I was young and [laughs] politically naïve. By law, the head of the department had to be a psychiatrist. The head of the department was a wonderful person and he recognized the problem. He said: "We have too many people in these institutions and we have to deinstitutionalize them but we have no money for programs in the community to support them."

The solution seemed obvious to me. We developed [laughs] a system -- remember I was very young -- to figure out the costs associated with each inpatient. We would then transfer the money associated with that inpatient to whatever the appropriate location of care in the community was going to be.

Now, just as this system was being implemented, the country had an economic downturn and states began to go broke, literally. The tax base just disappeared. Our goal was to move people from inpatient to outpatient status where it was much less expensive. We decided to take a percentage off the top and give it back to the state which was financially strapped.

In the midst of this, even though I started out as head of systems, I was promoted to chief financial officer and then I was promoted to deputy director for management. So I ran the operations of the department. The department head was a psychiatrist and, as I said, a terrific guy, but he was not a day-to-day manager. He supported me because this outpatient/deinstitutionalization approach worked quite well both clinically and financially. The money was following the patient so there was actually more money in the community for support. So you had clinicians asking for patients to be moved.

The point of that story is that we did the right thing clinically, while saving a lot of money. I became very intrigued by that because the broader American health care system spends too much money but doesn't always get the right result. So this is all apropos of your question.

The result was that I got very interested in health care and decided that I wanted to stay in health care, but as a manager, not a clinician. My thinking was that by changing how care is funded and the way it is delivered, we could both save money and improve care. Ironically, the financial situation got so bad that I was then promoted to director of the Bureau of the Budget.

Berkowitz:

For the State of Illinois?

Schaeffer:

Yes, for the State of Illinois and I was also appointed Chairman of the Illinois Capital Development Board which was the entity that issued bonds to build roads and that sort of thing.

I got very involved in state finance where the responsibilities went well beyond health care. But I always thought health care was the opportunity for good managers to have a major impact because we didn't have -- and still don't have -- a health care "system" in the United States. We have a mom-and-pop industry with various players self-optimizing. This means that physicians and institutions optimize their own situation but sub-optimize the system and its performance as a whole. I'm very intrigued by the notion of organizing and coordinating the delivery of care and doing a better job, frankly, with fewer resources.

Berkowitz:

I was just thinking that you're saying that a lot of the leaders in health care came from this sort of background -- systems people who turned their attention to health care. I was thinking of Stuart Altman.

Schaeffer:

Yes. Well, when I got to HCFA -- I worked with Stuart a lot. He's a very bright guy and a very good guy but he was much more research-oriented. And -- this is not a knock on Stuart -- he probably has a bit more ideology than I do.

I didn't have a political ideology around health care back then and still don't. My focus is on effectiveness and achieving goals with targeted and fewer resources because I think there's grotesque waste associated with delivering the wrong services to the wrong people in the wrong location. Moreover, it's harmful. In mental health, this issue was stark, but you see similar things in other parts of health care.

So the long story is that's why I got involved in health care. I stayed out for a while but I always came back to it. My interests are financing and delivery of care. I'm not a clinician, although I have a clinical credential I'm very proud of.

Berkowitz:

Which is what?

Schaeffer:

I'm a licensed apprentice pharmacist. My father was a pharmacist and he made me get the license so I could work behind the counter and deliver prescriptions after school. Although what's interesting is my license was signed by the only man ever to serve as governor of the State of Illinois, Chief Justice of the Supreme Court of the State of Illinois, and as an incarcerated felon in an Illinois State Prison. So the license has historic value.

Berkowitz:

So he began as a pharmacist in Evanston or where?

Schaeffer:

Yes, he was in downtown Chicago.

Berkowitz:

So let's try to get back to the story a little bit.

Schaeffer:

Sure.

Berkowitz:

Now, after disengaging from HCFA, you've done your probation period where you didn't want to work in health care.

Schaeffer:

Correct.

Berkowitz:

So then — first time up, you went to work in Minnesota?

Schaeffer:

No. I went to Sallie Mae. I did that because I thought it was an opportunity to achieve a public good through a private organization. It's a private company chartered by act of Congress. We're not doing the history of education policy today but you might take a look at that.

Anyhow, I did that for three years and then I went to Minnesota.

Berkowitz:

And in Minnesota you were operations officer for the...

Schaeffer:

No, I was President and CEO of Group Health of Minnesota. Group Health is a fascinating entity because it is a cooperative. It comes out of the model of agricultural supplier and producer cooperatives in the upper Midwest. What happened is that some people had taken that cooperative notion and applied it to a health care delivery system. What it means is that the owners are the patients. It is a brilliant model.

The problem is that the cooperative model is not well understood beyond the upper Midwest. But where it's understood, it's very effective, because you get people paying their premiums into an organization, an entity that they own, and utilizing the health care services. And, you know, I liked it a lot.

In Minnesota it's not so much liberal or conservative, it's progressive. It comes out of the experience that you get over the long winters when you could easily die if you don't have neighbors who will help you. So the notion is everybody cares about everybody else. Everybody is available to help. It comes from the culture of northern European countries.

Berkowitz:

So it's interesting that the entity in Washington, which also made political gains in its day and also is run in that same model, was very politically active...

Schaeffer:

I know the CEO who ran it for a long time, a really good guy, and it's a very good organization. But they had what they called member committees with oversight over everything and responsibility for many of the operating decisions.

We had a member board of directors. You had to be a member of Group Health to be on the board of directors, but it operated like a classic board. They did not get involved in day-to-day management. There had also been a very strong leader before I got there. They delegated authority to me to run the organization and it was a great experience. I learned a lot about the delivery of care. I learned a lot about how doctors think. I learned a great deal about customer satisfaction. It was a spectacular opportunity.

Berkowitz:

They actually had a strike of the doctors at the Group Health Association of Washington.

Schaeffer:

I don't want to go into the differences but in the upper Midwest the notion of a cooperative is a very powerful idea. It comes out of the agricultural experience that emphasizes: "We're all in it together. We're going to make this thing work."

Berkowitz:

It's sort of Scandinavian, too.

Schaeffer:

Yes, it's very Scandinavian. What I think happened in the group up in Puget Sound, which is an excellent entity, is that they lost track of "We're all in it together," and it became, as you say, more political. But Group Health in Minnesota was not like that at all and there was no political tinge. The ideology was not a political ideology. The ideology was based on the belief that: "We're in it together. We've got to do the right thing and we're going to do the right thing."

Berkowitz:

Did you -- when you worked at Group Health in Minnesota -- did you have contacts with companies like 3M or Cargill?

Schaeffer:

Oh, yes.

Berkowitz:

They were your clients in some way?

Schaeffer:

Some of them were. It just depended because we competed with all of the for-profit entities and the Blue Plan. The situation was a bit analogous to Kaiser in California in that certain people with certain mindsets would be attracted to the Group Health model. They would then stay in it for generations because it worked so well. It was an integrated financing and delivery system where there were personal relationships between patients and doctors, and all the clinics were out in the community.

One of the things we did that might interest you, and I maintained, is we never owned a hospital.

Berkowitz:

Unlike Kaiser which did own a hospital.

Schaeffer:

Well, that may not be wise because you end up with all that capital investment you have to pay for. The need to cover fixed costs may lead to higher utilization than may be appropriate. For free-standing hospitals, increased service volume helps support the enterprise. There's good data to support that. For an HMO, however, excess service volume can create financial strain.

So we never owned a hospital, but we contracted with community hospitals and the organization did very well. It was a great experience and I thought there were aspects of the Group Health model that could be used in other places. The issue with the Twin Cities is it's a relatively small population and there really weren't mechanisms to expand. I wanted to try some things on a larger playing field and that's why I ended up in California.

Berkowitz:

Let me ask another question about that if you don't mind my taking another detour in the conversation.

Schaeffer:

Sure.

Berkowitz:

When you were in Minnesota, now you're an administrator of a private health plan. So did you say to yourself, "Well... I know about Medicare because I was in Baltimore. I was in Washington. I understand the program and that gives me more insight about being able to utilize it properly, or profitably, or whatever?" Did you feel that you understood the reimbursement patterns in Medicare?

Schaeffer:

I think it actually worked a little bit the other way. I knew a lot about Medicare and Medicaid regulation but, being on the ground, you see how people really react. There was a great federal experiment going on at Group Health. We were a site for what was called the Social HMO. Does anybody remember that? It was not that different from an ACO. You know, everything old is new again.

As a site that delivered the Social HMO, we used to hold these meetings and the issue was that you had to be over 65 to enroll. So, basically, it was an HMO that had all the medical and social services that a person could need as they age. And...

Berkowitz:

Medicare Part C.

Schaeffer:

Yes, but even more integrated than that. It was a grand experiment and it should have worked.

We held these events where I'd sit and explain the program to people. They understood it and I'd say "Well, do you want to join?" And they'd say, "No." I'd say, "Why not?" They'd said, "Well, we don't need it now. As soon as we need it, we'll join." In other words [laughs], they saw the actuarial basis of insurance backwards. But they certainly understood their own self-interest.

The insurance concept is you're going to collect money from everybody but X number of people will not get sick and won't need services. As a result, you will have sufficient money to subsidize the few people who do get sick. Well, if you're not sick or you don't need the

extra social services that you don't get in regular Medicare, why should you pay the higher premium for the Social HMO? But when illness occurs, people want these services and are willing to pay because they understand their self-interest. It was a very interesting experience.

The other thing that was interesting was dealing with the doctors. We had a medical director who was a real salt-of-the-earth guy. It's very difficult for non-physicians to manage physicians but he and I, fortunately, had a very good relationship. Physicians are not trained, and still aren't, to feel a sense of responsibility for their financial impact on the organization or to identify with the system as a whole.

I now teach a class at a medical school to try to change this perspective. Medicine is frequently taught as if it is a specific transaction between two people. "It's me as the physician and it's you as the patient. I'm going to do the right thing for you, no matter what." The physician is trying to optimize at that level. That is, trying to optimize a single relationship in a manner that may or may not result in the most cost-effective care, but doesn't relate to optimizing the system as a whole.

To change that behavior by saying, "Well, this treatment is going to be more efficient," just doesn't work. But if you can say, "We're going to get a better result for that patient or all the patients with similar problems," that changes behaviors. So we invested heavily in automated systems to generate the data to understand costs and outcomes. Remember, I already had some experience in Illinois providing information to physicians. The big insight is that physicians are very data-oriented and will change behavior based on factual information. Most lay people tend not to change their opinions even in light of new information.

Berkowitz:
Right.

Schaeffer:
A doctor will decide: "Here's the diagnosis and here's the treatment." Then he or she gets test results the next day and if those test results vary from the previous day he or she will change the diagnosis and change the treatment.

So you have to get objective information and you have to share it quickly. It is not uncommon for physicians to feel that aggregated information prepared by a third party organization has been manipulated or incorrectly aggregated before they see it.

So what we did is develop a system that compared all the docs on the same basis and tracked outcomes. They're very very competitive, so, as an example, we looked at length of stay for uncomplicated deliveries — healthy mother and healthy baby. What we learned was that you don't need a long stay in the hospital. In fact, the longer you stay in the hospital, the more likely you're going to get a hospital-acquired infection or another type of complication.

Schaeffer:

Now, it's natural for a new mom to want to stay in the hospital, particularly if it's a first child. Childbirth is exhausting and brings a lot of new responsibilities for the baby that first-time mothers, in particular, feel unsure about. So new moms prefer to stay in what they perceive as a safe environment and it's easiest for the doctor to see them there. Unfortunately, hospitals are rife with germs and that increases the likelihood that either mom or baby will get sick. So the idea was: let's get those moms home but let's have an aide there to do household chores and let's have a nurse visit to help the mom understand how to care for her newborn. Overnight the delivery of care changed, quality and customer satisfaction improved, and costs went down as length of stay decreased.

We were basically following the classic HMO ideal of an integrated health care delivery system. While the physicians were not capitated, they were not paid fee-for-service either but were salaried. We received a premium from every member and we had a bolus of money that we could spend on integrated care.

Berkowitz:

But the employers are there somehow too. They're paying for it. They're saying, "Well, we don't pay to clean the house when the baby's born."

Schaeffer:

Well, it wasn't up to them if they were dealing with an integrated delivery system like Group Health. Now if you're dealing with a Blue Plan or you're dealing with a classic insurance company whose benefits are described as specific services with specific fees, there may be some difficulty. At Group Health we delivered -- or tried to deliver -- comprehensive care because it literally was an HMO. The money came in the top and there were no fee-for-service payments to providers. The docs were salaried. The nurses were salaried. Basically, everybody was salaried.

Berkowitz:

Yes, a real staff model.

Schaeffer:

And if you collect the data and you analyze the data you see, over time, what works and what doesn't work.

Berkowitz:

So let me ask another question. Did you see yourself as a player at all in the national health insurance discussion or is that something that was sort of beyond you in all this? You're really just running the organization day-to-day?

Schaeffer:

Well, one of the great things about Washington is that you have two options. You can stay in D.C. and try to fight your way above all the craziness to influence policy or you can leave town and, by virtue of not working in D.C., but by having real health care experience elsewhere, be considered an expert. [laughs] So when I visited D.C. I was considered an expert. And the further away you go, the better -- Minnesota was good; California was great. So, yes, I was involved. But by virtue of not being there full-time, I was less involved

in the political fights which can be very personal. Being an expert, who comes in from the outside to discuss specific issues, just worked better for me.

Berkowitz:

Oh, I see. So now how did you get to California then?

Schaeffer:

Well, I was recruited. California was a leader in HMOs and capitation because they had selective contracting which had been authorized by the state in the early '80s. Historically, insurance companies received a premium and when the patient gets care the company pays the bill. This process meant that the patient could go to any licensed provider and the insurance company had to pay for the services delivered.

Then in 1982, California passed selective contracting with hospitals and physicians. This allowed health insurance companies to pay for services rendered only by contracted providers.

I thought that was a spectacular opportunity because what you could do is figure out which providers were high-quality and cost-effective, and you could contract selectively with them. That was the notion. And that's why I went to Blue Cross of California.

Berkowitz:

Was that also Blue Cross/Blue Shield?

Schaeffer:

No. California is almost unique in that Blue Cross and Blue Shield are different companies and they compete with each other.

Berkowitz:

Okay, so was it Blue Cross, one of the Blue Cross organizations which presumably was authorized through an act of the state legislature.

Schaeffer:

Well, the history goes back a long time — to the '30s and '40s. Blue Cross plans came out of this experience with the notion of creating an insurance mechanism for hospital services. Blue Shield plans came out of an effort to create an insurance model for physician services. In California, uniquely, both Blue Cross and Blue Shield plans contract with both hospitals and physicians. Therefore, each plan funds both types of services and they compete with each other.

Berkowitz:

The insurance industry regulated at the state level...

Schaeffer:

Right.

Berkowitz:

Where those laws came from.

Schaeffer:

Correct.

Berkowitz:

They changed the law for Blue Cross and it was treated a little bit differently...

Schaeffer:

Well, no. In terms of insurance regulation, Blue Cross was not treated much differently. Historically, the Blues were not-for-profit which led to certain assumptions that regulators made including that they, allegedly, had some advantages in the marketplace. But, over time, all insurance entities were treated pretty much alike in California. However, HMOs were, and still are, regulated by a different state agency.

Berkowitz:

I see, okay. So this is an organization that apparently was in trouble when you got there.

Schaeffer:

Yes.

Berkowitz:

So tell me, could you be on Medicaid and then also use Blue Cross?

Schaeffer:

Yes. Blue Cross contracted with the Medicaid programs to provide services to Medicaid eligibles. We had a big HMO product for this population.

Berkowitz:

So this was a pretty big divide, a pretty big financial...

Schaeffer:

Blue Cross was the second largest health insurer in California but it did have financial problems.

I arrived in California in 1986 and I had all these great ideas about selective contracting, HMOs, etc. But after three months, I discovered that the organization had serious financial problems. "Insolvent" is a word you never want to hear. Blue Cross was put under secret supervision by the Department of Insurance because they were so embarrassed to discover that the company was in financial difficulty.

Berkowitz:

Right. So to the outside world of 90,000 members you say "Well, we're insolvent, so we're going to raise premiums." That apparently wasn't so easy.

Schaeffer:

Well, not only was it not easy; it wasn't appropriate. I had a rule that we couldn't raise premiums more than a certain percentage. There are lots of other things you can do besides raise premiums.

However, back in that era, raising rates was considered the logical thing to do. From World War II through the early '80s, if you look at the financial performance of the Blues, there were three good years and then three bad years, three good years, then three bad years, etc. This six-year pattern of gains and losses was called the underwriting cycle. What happens is you have good years, you're growing, and you're making money. So you either don't raise premiums as much as you should or you decrease premiums until you lose enough money that you have to jack them up again. It turns out that the cycle comes from exactly this wrong kind of thinking.

We were the company that broke that underwriting cycle. While everybody claimed there was a health insurance underwriting cycle, we had learned that it had nothing to do with health care; it had to do with pricing. When I got to Blue Cross of California I think there was one actuary there. When I left, Blue Cross had more actuaries than the entire Blue system.

Berkowitz:

Really?

Schaeffer:

We're getting back to data and analysis. The joke is that they didn't fully understand where the money was going and couldn't predict where it would go in the future. Therefore, they didn't price right. So we did three things. First, we built better information systems. Second, we hired actuaries to analyze past experience and estimate future service volume and costs. And third, we tried to come up with ways to avoid significant price increases.

The great irony is that five years ago (after I left), it was Blue Cross of California that raised their rates 33 percent and the ACA passed. The cruel irony of that is that it turns out their calculations were wrong and they only needed 25 percent. But in the old days, we pursued alternatives to raising premiums: create narrow networks, change benefit designs, or adjust co-pays and/or deductibles.

Berkowitz:

So this was an era when Blue Cross, in general, is going to change and you merge into this different kind of more profit-oriented organization.

Schaeffer:

Well, let's not confuse profitability with the changes that were occurring. Back then the big issue was HMOs, and I was a big fan because I had seen what had been done in Minnesota. Selective contracting, which they now call narrow networks, turned out to be an extremely successful way of reducing costs and improving quality. It turns out that if you gather the data and analyze it, there's a huge difference in the experience that patients have. There are a lot of provider entities that aren't able to deliver quality care at an affordable price and there are many entities that can do both. The trick is to narrow the

network not just to reduce costs, but to make sure you get quality and customer service too.

So we started an HMO called, CaliforniaCare. We also developed narrow network products for small businesses because small employers are much more price-sensitive. At one time, the Blue Cross of California small business enrollment was, I think, as big as the whole system. These approaches were very successful.

Berkowitz:

Did you get a lot of pushback from the hospitals saying you couldn't do all this, you know, selectivity about what's good, and what's bad, and what's effective? We're also, you know, part of the community and we're part of a traditional relationship with Blue Cross.

Leonard Schaeffer:

Well, there are a number of aspects that are sort of California-centric to this. Long before I got to California, there was an attempt to use selective contracting for Medicaid. They hired the former head of Blue Cross to do this. He was a real tough cookie and he just scared the hell out of many hospitals which entered into discounted contracts without really understanding their own costs. They really had no idea. So Blue Cross also began contracting directly with these hospitals and, when I arrived, it believed it had great, low-cost contracts in place.

In my second month as CEO, I was going around visiting operational units. One day I visited the basement of the headquarters where there was a shift from something like 12:00 a.m. to six a.m. The manager, who was a long-time Blue Cross employee, told me about what it's like to be there at night.

One of the questions I asked him was, "Do you have any difficulty calculating the contracted discounts when you receive hospital bills?" He replied, "Well, the system doesn't calculate discounts." I said, "You know, we've got 30 to 40 percent discounts," [laughs] and he said, "Yeah, but the system can't take the discounts."

You see we had reduced our premiums 30 to 40 percent based on the hospital discounts. Yet, he was telling me the system didn't take discounts. So, literally, that morning, I went to the finance department and asked to see the cash flow. That's how I found out that we had real financial problems. The books showed us paying the hospitals at the discounted levels, while the cash flow showed that we were actually paying them at full price.

Berkowitz:

I see, I see. That's interesting that an organization so large doesn't even know that it's bankrupt.

Schaeffer:

Well, if you want to talk about management, the larger the organization, the more likely the person at the top doesn't know all the details of what's going on. That's why you have to build information systems. But it was a great lesson in life.

Berkowitz:

Yes.

Schaeffer:

A great lesson in life: always check the cash flow.

Berkowitz:

So maybe you could tell us a little bit more about this story about Blue Cross and then there's WellPoint.

Schaeffer:

Oh, okay.

Berkowitz:

You're key to that whole transaction, right?

Schaeffer:

What happened can be viewed from many different points of the compass. When I got there in 1986 we were the worst-performing Blue Plan in America. Now, as it turned out, we were also among the largest and so we had a very difficult three-year turnaround.

When I started, there were 6000 employees; I had to lay off 3000 people to keep the company afloat. You don't ever want to go through that, particularly when it involved minorities and single-parents who were not at fault. Now, for the record, I fired every single executive who reported to me when I got there because they were responsible for causing the problem. And, then, we turned the company around.

So by 1989, we were the best-performing Blue Plan in America and [laughs]...

Berkowitz:

So who was your rival when you were doing that? Who was an out-of-state Blue Cross Plan that you would have said, "Oh, yeah. They're also very good."

Schaeffer:

I think Chicago, at that time, was pretty good and then maybe one or two others. Alabama had something like 80 percent of the business in Alabama. I mean, literally, 80 percent of the population was covered by the Blues. If you look at health care in America, geography is destiny and it's a different story, in every state.

Berkowitz:

What's interesting is that it's Blue Cross of California. It's both San Francisco and Los Angeles...

Schaeffer:

Right.

Berkowitz:

-- and San Diego.

Schaeffer:

Right.

Berkowitz:

Other places that would be, you know, other states they'd be divided up in...

Schaeffer:

Well, that's true for Medicaid. In California, Medicaid is administered at the county level. You want to choose which county you're going to do business with.

But the point of the story is, by 1989, we're the best-performing Blue Plan in America. Then I realized that is a lousy comparator. These Blues were not all first-rate organizations and they were not our competitors. Also, the Blues were mainly about financing. But financing gave us a very indirect ability to have impact other than through contracting and collecting data, and giving that information back to doctors and the hospitals.

So when we looked around, most of our competition at that time was from very rapidly growing HMOs which were all for-profit. I was beginning to worry about losing members and good employees to these for-profit HMOs. Now, ironically, because of what we did next, it didn't happen, but that was the fear. So, as I said, we started our own HMO. We were very aggressive in developing CaliforniaCare as an HMO product with a narrow network to compete with the other HMOs.

As part of their growth strategies, the for-profit HMOs were acquiring smaller HMOs and insurance companies. So we decided to establish a for-profit subsidiary that could also make similar acquisitions. But it turned out that we didn't have enough money to do the acquisitions we wanted. However, our competitors were publicly-held, meaning they could print stock certificates and use them as acquisition currency to purchase entities that we couldn't afford.

So we went through a process called "conversion" that had been done many times in California, but I believe the facts are we did it very differently. And that is, under California law, it is possible to convert from not-for-profit to for-profit status, provided the benefit that has been created by the not-for-profit is transferred to a charitable foundation. And so the HMOs back then, which had started as not-for-profits, had a Wall Street investment banking firm come in and say, "You know, you're worth \$10 million." Then the HMO went public and gave the foundation \$10 million. But, guess what? The HMO was really worth \$100 million. Everybody involved made a lot of money... a lot of money.

You know, I didn't buy that approach. Members of our board didn't buy it either. So what we did was convert from not-for-profit to for-profit but gave all the stock to two foundations. We actually gave away over \$4 billion in value.

Berkowitz:

Really?

Schaeffer:

Yes, that is one of my proudest moments. Actually, when we subsequently completed all the WellPoint acquisitions, we gave away about \$6.4 billion in total. And they're all foundations that exist today.

So the idea was to create this entity that could make acquisitions and then we proceeded to acquire. We acquired a pharmacy benefit manager, we acquired the Blue Plans in Georgia, Missouri, and Wisconsin, and we acquired a workers' comp company. We acquired a lot of health care-related entities.

Berkowitz:

This entity that was Blue Cross in California, formerly, is now acquiring Georgia...

Schaeffer:

Other Blues, right.

Berkowitz:

Yes, okay, that's a little strange to me but I guess that was happening.

Schaeffer:

Well, we made it happen. It has happened many times since but it hadn't happened previously.

Berkowitz:

This is an all national operation now?

Schaeffer:

Yes, we became a national firm called WellPoint. We also had a subsidiary called UniCare, which operated where we didn't own a Blue Plan, and which didn't endear me to the other Blue Plans, but that's another story.

Berkowitz:

They said you're violating the social mission, perhaps, of the Blue Cross movement.

Schaeffer:

Back then, the Blue Cross/Blue Shield system really was not a system, it was more like a club. And the rules of the club are: you don't compete; that is, for example, if you're Blue Cross of Alabama you don't compete with Blue Cross in New York. If you're in California, however, and you're fighting tooth and nail with Blue Shield for customers, it's hard to think of yourself as a member of the club, particularly when the competition is not very pleasant.

So, we didn't come out of that mentality. Now there are several multiple Blue Plan organizations today but they didn't exist back then.

Berkowitz:

And you were competing with Blue Shield because you had gone into the physician business?

Schaeffer:

That happened long before I got there. The history of the California Blues, for reasons that are lost in the sands of time, is that both Blue Cross and Blue Shield went beyond their original mission. So the Cross “hospital-only” plan started contracting with doctors and the Shield “doctor-only” plan started contracting with hospitals. These changes occurred long before I arrived and they allowed both companies to offer employers comprehensive medical benefits.

Berkowitz:

This was already broken down.

Schaeffer:

And it was originally, I think, more geographic. Blue Shield was strong in the north and Blue Cross was strong in the south. There was a lot of crazy competition that predates me. But when I got there we were real competitors and it was very confusing because most people didn’t know if they belonged to Blue Cross or Blue Shield and I think some damage was done to the brand as a result. I tried to say, “Look, we’ve got a very powerful brand. We’ve got to be careful about it,” but that brand has sort of gone by the wayside, not just in California.

But the point I’m trying to make is that the movement to for-profit was not some avaricious scheme to make our executives wealthy. When we converted from not-for-profit to for-profit, we gave the foundation the entire value created by the not-for-profit, Blue Cross, by giving them all the stock.

Berkowitz:

Most people think that’s the case.

Schaeffer:

They can think all they want but that doesn’t change the facts of what happened.

If those foundations had held onto the stock, they’d be among the biggest foundations in the world. However, one of the foundations was obligated to monetize the stock to get cash to fund the second foundation.

What’s fascinating about being a publicly-held company -- a stockholder-owned company - - is you get a report card every quarter when the company publishes its results which, in turn, influence the stock price. Wall Street has all these analysts watching you.

Berkowitz:

Right.

Schaeffer:

And they come up with their own figures about what performance they expect. We also had an advisor who said that, to be taken seriously -- because, remember, we were using the value of the stock to acquire things -- your firm has to grow by 15 percent a year, compounded. [laughs]

Berkowitz:

This is just the conventional wisdom?

Schaeffer:

I don't know where it came from but I'd never run a for-profit company so that became our goal. Over the time that I was there, we grew by 22 percent a year, compounded. I got a relatively low salary because the Board gave me stock options. But WellPoint performed very well, which was reflected in the stock price, so I ended up being well-compensated.

Berkowitz:

Yes, that's good. WellPoint, I still haven't heard about the actual creation. I see that's going on here -- that you're going to move into different areas.

Schaeffer:

So WellPoint: WellPoint actually was a for-profit subsidiary we started with in 1992.

Berkowitz:

Okay.

Schaeffer:

There were literally 18 law firms involved in the conversion and recapitalization that resulted in WellPoint switching from the subsidiary to the parent — that is, WellPoint ended up owning Blue Cross of California, among other things. Now, that turns out to be very difficult to do until Blue Cross of California became for-profit. And so as we acquired other Blue plans, they became for-profit as well and, therefore, they could be owned by WellPoint.

We replicated the Blue Cross conversion model. When a Blue plan converted to for-profit so it could be acquired, we gave the value that was created to a foundation. To explain, by virtue of being shareholder-owned, WellPoint could buy Blue plans with stock and, as part of that conversion process, that stock went to a foundation. In our approach to conversion, the stock used to purchase the plan, did not go to individual employees, so they did not make money on the conversions.

We created two foundations in California. There's a foundation in Georgia, one in Missouri, and one in Wisconsin. WellPoint also has its own foundation. Over six-and-a-half billion dollars was given to charity.

Berkowitz:

So when they say, "What is WellPoint in the business of," it's in the business of health insurance, or health, or --

Schaeffer:

Well, WellPoint was, hopefully, in the business of financing health care and doing it in a way that would make care both more affordable and higher-quality. And there were a number of mechanisms it used. The biggest one, the most well-known one, is its role as a health insurance company. But we also had a lot of HMOs and a lot of narrow network plans. We also had other insurance-related products. We had our own pharmacy benefit manager. We had a worker's comp plan. We had other forms of insurance.

After I left, the company evolved and it has returned to a much more traditional, health insurance company.

Berkowitz:

Who's the customer, the employers?

Schaeffer:

Well, that's a very important question because, historically, the Blues, like most insurance companies, would say that the customer is the entity that pays the bills. So it's the employer.

Berkowitz:

How about the unions?

Schaeffer:

We had a lot of union business but, based on both the mental health experience and the Minnesota experience, that's not my perspective at all. The employer or union is the fiduciary, but the real customer is the individual employee -- the insured individual or the HMO member. So, the focus should be on meeting the needs of these customers.

Large corporations have a benefit staff and the benefit staff likes to deal directly with employees. They don't like insurance companies to do that. But, as you go from giant corporations down to smaller and smaller firms, there are fewer and fewer people in the benefit department and so the individual employee feels vulnerable and not supported. They're all by themselves. So what we tried to do was to build customer services that could deal directly with individual employees whom we insured or were members of one of our plans.

We had a rule, you'll find this amusing. No communication could leave the company, and back then everything was on paper, unless it was signed by a real human being and there was a telephone number that a customer could call.

Berkowitz:

That's good.

Schaeffer:

You won't find that from your insurance company today [laughs] because nobody does it anymore. But the point was to maximize the member experience with us and, hopefully, with the physician, or the hospital, or whoever. So this is a long answer but it's a very important difference. For example, Cigna is a classic large group insurance company and they're very good at it. Their customers were usually large employers and, historically, when I was active in the insurance world, they related primarily to the employer, or more accurately, to its benefits department. Our theory -- since we were usually serving smaller employers -- was that we're going to relate to the member, not just the employer and its benefits department, in order to create a better experience.

Berkowitz:

So now I want to -- we're heading toward the end of our session but I want to ask you two more questions.

Schaeffer:

Sure. [laughs]

Berkowitz:

The first question is how important having been the head of HCFA was to you. When you became a big figure in the private insurance business, did you see yourself as a member of the club, of former CMS administrators?

Schaeffer:

Yes.

Berkowitz:

Do you actually see these former administrators on any sort of regular basis?

Schaeffer:

Well, maybe seven or eight years ago, I started having a dinner at my house to bring them together because there are now so many of us. At these dinners, we discussed health policy and, particularly, health care legislation in the United States. I also began to recognize that the debates in Congress are never really about health care. They're about three things. It's about money because health care costs are 17.4 percent of the GDP and growing. It's a tremendous amount of money on the table and, if you're an elected official, that also means taxes. If you're in the private sector, it means profits or losses, so, in the legislative process, it's first about money.

Secondly, and uniquely in the United States, it's about the role of government. There is a tremendous amount of ideology about what is the appropriate role of government. Particularly with health care, it's a very dicey set of circumstances. We come out of a history captured by a quote often attributed to Thomas Jefferson: "That government is best which governs least."

Berkowitz:

We show to the individual.

Schaeffer:

So, the third thing that the legislative process focuses on is about social values. Social values are a nice way of talking about abortion, how we die, and a bunch of things that have health, religious, and social aspects.

So when you're running HCFA or you're running CMS, you'd like to think that it's about health care and about financing it. But, it's really also those three overarching issues because they are so important to elected officials and to the public. Therefore, it's a very challenging job and different people come in with very different backgrounds. So there's a sense of mutual support and camaraderie independent of political party or ideology. There's a sense of "Gee, hope you come out of this alive."

I was probably the least well-trained for the job but could be the most aggressive because I was only the second person to serve as Administrator.

Berkowitz:

CMS, similarly...

Schaeffer:

Well, I started long before CMS, when Califano -- I think this is in your previous interview -- grasped what had to be done. He saw that Medicare, which was administered as a program for older people who deserved help and were called "beneficiaries," while Medicaid, which was a program fraught with scandal, and whose beneficiaries were called "recipients"...

Berkowitz:

Right.

Schaeffer:

Wrong. Califano understood that these are both health care programs. My contribution was realizing that if you put them together and do it right, [laughs] you create the largest purchaser of health care services in the world and we could bring health care costs down. We could actually get it done.

Berkowitz:

At some point somebody must have said, "Gee, the government is the largest single payer of health in the United States. How did that happen?"

Schaeffer:

Two of the great difficulties -- and this is not a cheap shot -- are that most members of Congress do not understand the details of either of these programs, but they have an ideological worldview. That view is not an operational one that acknowledges each state Medicaid is different and, now, that the ACA is a science experiment in each state. So, it's unfair to say that members of Congress are dumb because it's so hard to know the details of what's happening in such large and complex programs. But, if you're the Administrator in the middle of it, the pressures to understand and direct operations while also dealing with ideological issues and Congressional oversight are very intense.

The other issue is that, Bob Derzon, who was the first administrator and a really good guy was very philosophical. A number of the administrators have also functioned at a philosophical, policy level. You know, I was very young and my focus was let's get it done.

Berkowitz:

Right.

Schaeffer:

I think I have some important policy insights but they're not ideological. At least, I don't think they are -- I mean, you have to test that for yourself. They're about efficacy and so that's how I tried to run the agency. I was trying to create a vision of the future, a mission, a set of quantifiable goals, and make people feel good about trying to achieve them.

This morning, an older gentleman came up to me, after I'd given this talk at the NASI Conference on Medicare and Medicaid, and he said, "I want to thank you." He said he worked for the HCFA/CMS policy shop and, years ago, he got a commendation from me. I strongly believe you should give awards to recognize and reward performance. The man said the commendation has been hanging on his wall all these years and he just wanted to say thank you.

There was a point in time when people were proud to be involved in that work.

Berkowitz:

Yes.

Schaeffer:

I mean, really proud.

Below are appended Mr. Schaeffer's written answers to a set of questions that were offered as examples of potential types of questions prior to the interview. Mr. Schaeffer generously sent the written answers after the interview to supplement the interview discussion.

To: Leonard Schaeffer, Judge Robert Maclay Widney Chair and Professor, USC

From: Ed Berkowitz, Professor of History and Public Policy, GW

Re: Questions for January 28th Interview

INTRODUCTION: We last spoke in 1994 as part of an oral history project sponsored by CMS that focused on your transition from state to federal government and your service as head of the Health Care Financing Agency. Since that time you have had an illustrious career in the health care industry at, among other places, Blue Cross of California and at WellPoint. What follows are some sample questions for our interview:

1. How did you make the transition from the private sector to the public sector of the health care industry?

- I served in both federal and state government and in the private sector in not-for-profits and for-profits.
- I began in health care in the public sector and transitioned to the private sector.
- My first experience in health care was state government in Illinois as Deputy Director of Illinois Dept. of Mental Health and Developmental Disabilities (1972-1975)
- Then I became Director of the Bureau of Budget in Illinois; spent 2 years at Citibank; and then went to the federal government, first, as Assistant Secretary, Management & Budget (HHS) and then as Administrator of HCFA.
- Subsequently, I was COO of Sallie Mae, then ran Group Health, a not-for-profit, integrated financing and delivery system in Minnesota.
- I moved to California in 1986 to take over Blue Cross of California which, at that time, was both not-for-profit and facing serious financial problems.
- We turned around Blue Cross in three years and built WellPoint over the next 20 years. WellPoint became for-profit and, during my tenure, the largest health insurance company in the U.S.

2. Were there lessons that you learned in the federal government—and in HCFA—that you were able to apply to WellPoint and your other endeavors?

- Some lessons learned about organizations that I continue to apply:
 - Large organizations resist change.
 - Difficult to establish new behaviors because organizational culture deeply entrenched.
 - Clarity and consistency required for mission and vision.
 - It is important to have a process for setting time-specific, measurable goals, assigning accountability, reporting results, and taking corrective action when necessary.
 - Communication must be a priority.
- Lessons I learned about leadership in large organization include:
 - Leadership requires authenticity. This means leaders:
 - Must always be confident in their own decisions.
 - Must believe in the importance and value of the enterprise.
 - Can't ask of others what they won't do themselves.
 - Must be brutally honest about results.
 - Should be prepared when meeting with the media.

3. What are the chief differences between managing an organization like WellPoint and administering a big federal agency?

- **In the private sector, the “span of control” is narrower compared to a federal agency. This means that:**
 - Public sector has more constituencies to deal with.
 - Private sector has a bottom-line which gives greater ability to establish goals and measure achievement.
 - Federal employees are focused on an agency’s traditional processes, while private sector employees are more invested in the company current goals.
 - Private sector boards are easier to deal with compared with dealing with Congress (where elected officials are your bosses).
 - Public sector has more amorphous goals and accountability although its goals may be more important social goals.
 - Private sector can move faster and is more able to reorganize structurally when necessary.
- **Private Sector has effective tools to motivate its workforce:**
 - It can remove employees who do not agree with vision/goals/plan; and
 - It can financially reward those who contribute towards achieving goals.
- **Both sectors have “politics” but they are different:**
 - Public Sector has complicated, “trade-off” politics which often leads to elected officials giving managers mixed messages and to concerns about media attention and partisan politics.
- **A Harvard Kennedy School of Government Case Study entitled, *Managing Change: Leonard Schaeffer at HCFA and Blue Cross of California*, compares my two leadership experiences**

[\(see: http://www.hks.harvard.edu/case/caseweb/catalog/abstracts/\)](http://www.hks.harvard.edu/case/caseweb/catalog/abstracts/)

4. As administrators for CMS come and go, is there any advice that you would offer them, based on your own long administrative experience inside and outside the federal government?

- Get going as soon as appointed; “you’re dead in 18 months”.
- Try to build an institution vs. just getting legislation passed.
- If you’re not from a management background, talk to successful managers and scan the organizational management literature.

5. Did the problems at Blue Cross in California that you encountered foreshadow more general problems in the health care industry?

- Yes, in two related ways:

- First, California, a bell-weather in health care, was undergoing a difficult, but inevitable transition to managed care.
- Second, Blue Cross, like many other Blues, was not positioned to succeed in this new environment because it was poorly structured and facing significant marketplace challenges unique to Blue plans:
 - Blue Cross was a taxable nonprofit corporation prohibited from engaging in any business other than traditional health insurance;
 - Blue Cross was unable to access capital markets; and
 - Blue Cross was unable to take the actions necessary to compete against better positioned public companies and tax-exempt nonprofits.

6. What was the nature of your work at WellPoint?

- I think about my work at WellPoint in eight distinct phases that relate to the leadership style I felt required to achieve the goals of each phase.
- These eight phases are described in a Harvard Business Review article, entitled “The Leadership Journey”. The article can be accessed at:
<https://hbr.org/2002/10/the-leadership-journey/ar/1>

7. What happened to the health insurance market in California in the 1990s and how did federal and state policy factor into the situation? Did your background as a HCFA administrator help you to understand and respond to the problems that arose?

- By 1990, California had an intensely competitive health insurance market. Federal and state policy played a direct role:
 - The 1973 Federal HMO Act provided start-up funds which spurred HMO growth; 35 HMOs in California by 1990. In 1979, HMO Act amended to allow NFP HMOs to convert to FP to gain access to capital; through 80s and 90s wave of HMO conversions resulted.
 - At the state level, 1975 Knox-Keene Act transferred regulatory authority to the DOC to bring financial stability to health plans using its expertise in financial regulation.
 - At the state level, 1982 law passed allowing selective contracting for hospital and physician services paved the way for indemnity insurers to create PPOs.
- The intensely competitive environment required focusing on controlling the underlying provider costs that drove premiums instead of acquiescing to higher reimbursement.
- I came to believe that Blue Cross had to restructure. We needed Knox-Keene licensure to offer managed care products and the ability to access capital.
- The restructuring and simultaneous conversion of Blue Cross to for-profit status was very controversial.

- At HCFA, I dealt with multiple controversies and bad press. On the one hand, I tried to focus on internal operations but, at the same time, I tried to be well-prepared and not let media events distract me from achieving our goals.

8. Could you talk about the relative roles of private industry, academia, and the federal government in the development of effective health policy?

- In brief, it is the poor interaction among these three players that leads to health policy that is not effective and not based on evidence.
- Historically, too, East Coast academia has had a disproportionate influence on federal health policy.
- I think that private industry needs to increase its interactions with academic researchers to identify policy-relevant questions.
- Researchers need to collect the data, turn it into information, and provide public and private policymakers with that information for decision-making.
- Policymakers need to make sound policy decisions based on that information and implement them.
- Researchers then need to play a role in evaluating those policies in order to make improvements.

9. What does your work in the private health care financing sector tell you about the continuing role of the federal and state governments in this field and in particular about the future of Medicare and Medicaid?

- We are potentially headed towards what I think will be an American version of a “single-payer” system.
- For health plans, government business (Medicare, Medicaid, and subsidized Exchange enrollees), represents growth areas and is accounting for an increasing share of their business.
- When Government becomes the majority payer, it will be able to control costs using blunt cuts and heavy regulation of both plans and providers.

10. At HCFA and in the private sector, you had to make coverage decisions that had significant financial consequences. Can you talk about how you made those decisions and the role of scientific evidence? Today, research and data are used extensively in these kinds of decisions. Was that true when you were in government? If not, how were decisions made?

- There was not a lot of evidence back then; today, we have more data but evidence is frequently not used or ignored.
- Physicians and their specialty societies establish standards of care and it is difficult to make coverage decisions that go against those standards.
- Moreover, patients and their families use the media, social media and political pressure to access treatments they want even when there is no evidence that such treatments will be effective (and may even be harmful).

- Coverage decisions are comingled with social values and the medicalization of social or behavioral problems (e.g., obesity, substance abuse, and autism, etc. are not well understood, but health plans are required to cover specific treatments or therapies.)
- Health plans today are changing benefit designs to try to control the costs of certain treatments. For instance:
 - Establishing narrow networks with cost-effective providers;
 - Implementing financial incentives to encourage use of particular specialists; and
 - Reducing coinsurance for drugs for chronic conditions (e.g., diabetes, asthma) to encourage patients to use them to better manage their illness.

11. Could you discuss the evolving role of medical technology and information technology in the provision of health care during your tenure at HCFA as well as during your tenure at WellPoint?

- At HCFA, I wanted to implement a Uniform Hospital Reporting System to capture hospital data that I thought we needed in order to understand where the money was going.
- I went to Congress about this proposal and got totally shut down.
- At WellPoint, I was more successful. When I first came to Blue Cross, I quickly learned that everyone was focused on paying claims.
- After I arrived, Blue Cross built an actuarial department to analyze costs and utilization that employed more actuaries than all of the other Blue plans combined.
- The turnaround of Blue Cross required that we understood our own costs related to specific benefit packages and risk pools in order to stop the hemorrhaging.
- By the time WellPoint was created, we had established sophisticated IT systems to turn claims data into information to set appropriate rates and to help customers gain access to cost-effective providers.

12. An early theme at CMS was the attempt to integrate Medicaid and Medicare. You have already talked about this matter in your previous interview. Do you have further thoughts on the matter? HCFA was created with the intention of merging Medicare and Medicaid. How well has it succeeded? What steps still need to be taken?

- My efforts to integrate Medicare and Medicaid were challenged by prevailing social values.
- In brief, helping old people who paid into Medicare was viewed differently than helping poor people.
- I think some vestiges of that thinking still persist, especially in Congress.
- Social values may help explain why we have not moved towards integrating funding streams for dual eligibles or change Medicare benefits to include more social services even though demonstrations suggest these would be effective approaches.

13. You are now a Medicare beneficiary. Has your opinion of how the program is designed and administered changed now that you are a beneficiary?

- No.
- However, I am angry at both Medicare and my Medicare plan for sending me unintelligible messages and not including the name of a person that you can call or email to get clarification.

Interview with Thomas Scully

By telephone on May 19, 2015

Interview conducted by Edward Berkowitz

Transcript edited for clarity.

Berkowitz:

Today is May 19th, and I'm talking by telephone with Thomas Scully, who is in Washington, DC. We'll talk a bit about his background and his work at CMS. I know that you went to the University of Virginia and graduated 1979. I don't know much else about your upbringing. Could you please talk a bit about that?

Scully:

I grew up outside Philadelphia, in Springfield Pennsylvania. I went to a lot of Catholic schools. Up through 12th grade I went to Catholic schools in suburban Philadelphia, and then went to high school at a little school called Archmere Academy in Claymont, Delaware, -- the only person of note I can think of who went there is Joe Biden. It's an all boys Catholic school, right on the border of Delaware and Pennsylvania.

Then I went to UVA, and -- as you mentioned -- I graduated in '79. One of my better friends at Virginia was Marvin Bush -- least known of the Bush sons, and the one who likes politics the least. And so, in the summer of '79, when I graduated, I was up here looking for a job and bartending in Alexandria, I volunteered at the George Bush for President Campaign in '79, when he was about completely unknown. I think he was about half of one percent in the national name ID polling. But I had to go on and get a job. So, I did get a job. But I got to know those folks in the summer of '79. Bush obviously did not prevail running against Reagan in '79 -'80.

Then I worked at the Federal Election Commission for a year. After that I worked on the Hill for Senator Slade Gorton from Washington State for five-and-a-half or six years while I went to night law school.

Berkowitz:

Did you work on Senator Gorton's personal staff?

Scully:

Yes; I did no healthcare.

Berkowitz:

So what did you do?

Scully:

I started off as the Office Manager. I was going to night law school. Then I worked on legislative issues on the Small Business Committee and the Commerce Committee. I was there about five and a half years. He was the former Attorney General of Washington

State and was very supportive of me going to night law school. He helped me out a lot and was a great guy. I worked there until I finished law school. Then I went to Akin Gump.

Berkowitz:

You went to Catholic University for law school?

Scully:

Yes, I went to Catholic's law school at night while I was working in the Senate. GW and Catholic both had night programs. I think Georgetown might have had one too actually. But for some reason, Catholic seemed to be the one that had the most people from the Hill going there.

Berkowitz:

And what was the name of the firm that you worked with first?

Scully:

When I graduated law school I went to Akin Gump Strauss Hauer and Feld which is a big Texas firm -- one of the bigger firms in Washington. I went there to be a telecommunications lawyer because I worked on the Commerce Committee and I thought I wanted to be a telecom guy. So I did that -- a mix of telecommunications stuff and general political work, legislative work, for about, I guess, two and a half, three years. And then in the spring of 1988 when Bush started running again I took a leave of absence in the firm to go to work on the campaign for Bush Senior, intending to go back, and I never did. I basically did press work -- press and TV work, not policy work, believe it or not, on the campaign.

Berkowitz:

Did you meet the other George Bush in 1988?

Scully:

Yes, I met him. I didn't really know him. He was around a little bit. All the Bush kids were involved in the campaign a little bit. But I didn't know him well enough to have any personal relationship. Do you want all this detail?

Berkowitz:

Yes. Good.

Scully:

Okay. So I worked on the campaign. I was the Communications Director of the Convention, basically. I put together the press staff of the '88 Convention. I spent about three months doing that, and then when the convention was over -- people forget Bush was losing by 18 percent to Dukakis September 1st. He was way, way down in the polls. The election was basically over. I was going to go back to the law firm, because my boss at Akin Gump was Lloyd Bentsen's campaign manager. He wanted me to come back because it looked like the election was over. But the Bush people convinced me to stick around for the fall; I had this satellite TV campaign that we ran. I basically did press stuff. I was booking Bush and Quayle, and others, all fall -- I was the TV guy. When Bush got elected, I think he thought I was a TV producer.

Berkowitz:

How was Quayle on TV?

Scully:

He was a very nice guy. He wasn't great on TV. I was in charge of putting up all the debate responses when he debated Lloyd Bentsen. You may remember one of the more famous moments of debates was when he made the John Kennedy comparison and got hammered.

Berkowitz:

I've been told also that the older Bush, 41m is quite good in smaller groups, but not so good at mass campaigning. That true?

Scully:

Yes. I think anybody would say that including him, probably. He's one of the nicest human beings that ever lived. He is every bit as nice and pleasant and genuine in person as you would think from watching him from afar.

You probably know his history as well as I do, but had Reagan not picked a new VP his (Bush's) political career probably would have been over. I don't think he was a mass merchandise candidate from the beginning. He's always had millions of personal relationships; he's very good at keeping up with people, has his network of friends. It's incredible. He had a totally different set of skills than a Ronald Reagan or a Bill Clinton, as far as broad political speech appeal.

Berkowitz:

After the campaign, you went to work for him?

Scully:

Yes, as I said, in the fall I went and did TV work and produced stuff. Then we won, and they wanted me to go work in the press office for the transition to the White House, and I just didn't want to do that. I said, "Look. I'm a policy guy. I'm going back to the law firm." And they said, "Well, if you don't want to do press work why don't you go be the deputy at the transition for Congressional Affairs," because they needed somebody to get all these guys confirmed. So I went over to the deputy, a woman named Janet Mullins, who later worked for Jim Baker. We had to get all the people -- before the administration started, they nominated people. They had to get to them going on their confirmation process. So I was assigned to the work and this is related to how I got the next job I went to.

I had about half the Cabinet to get confirmed, and most of them had some of their own staff, but I spent a lot of time with Dick Darman, who didn't really have the staff, who was up for up for OMB director, and Secretary Brady, and a guy named Sam Skinner who was up for Secretary of Transportation, and a few others that didn't have as much staff. Anyway, I was offered a number of different jobs, and the one that seemed most appealing was the one at OMB to be the Associate Director of OMB, working for Dick Darman.

I went over to OMB to do what's called the PAD (Program Associate Director) job. There were three Associate Directors of OMB at the time, three domestic policy ones, and one foreign policy one -- one defense and foreign policy. I said, "Look. I don't know anything about health, education, or welfare." And Darman said, "Well, the other jobs are gone. It's the only one left. If you're going to come over here you're going to do health, education, and welfare, and learn them."

I went to OMB not knowing the difference between Medicare and Medicaid in 1989. But I had probably 150 staff, and they were great. For better or worse, the good thing about Republican administrations is in social policy there aren't that many people engaged.

At the time, Bill Roper, who had been HCFA Administrator under Reagan, was the Deputy Domestic Policy Advisor, and he and Darman got along fine. I was doing health and welfare for Darman and we became good friends. So Bill and I were the healthcare team for the first year, basically. I didn't know a lot about healthcare, but I had a big staff, and I had a lot more legislative experience than Bill did. So I went to work for Darman as the Associate Director for OMB, and Bill was over doing the Deputy Domestic Policy and we became a team. He left after about a year.

Our first year we had to try to save the Medicare Catastrophic Coverage Act, which was the drug benefit that had got passed in '88, and we passed RBRVS (Resource Based Relative Value Scale) -- the physician fee schedule. Bill and I spent our first year trying to save Catastrophic and passing physician payment reform. It was a pretty wild first year.

Berkowitz:

What was your take on the politics of that? Why did the Catastrophic Coverage Act get repealed in 1989?

Scully:

My take on it was it was good policy, probably better policy in many ways than what we passed later for drug coverage, because it was really focused on subsidizing poor seniors. And the politics of that was that it was basically a deal between Reagan and Democratic leaders; essentially it was run through by Dave Durenberger, Jay Rockefeller, Pete Stark and Bill Gradison. And it was raced through Congress in '88 without a whole lot of intense discussion and debate. It essentially taxed richer seniors -- there was nothing coming out of people under 65. It was a redistribution from wealthier seniors to poorer seniors, and that was probably the right thing to do.

But immediately after it passed, there was an outcry to get rid of it, and repeal it -- led by Representative Bill Archer, who was later the Chairman of Ways and Means, from Texas, and Senator John McCain, who at the time was up for election in the next year in Arizona, and was a young guy back then. He was worried that the seniors in Arizona, wealthier seniors, were going nuts about paying more for the benefit than they were going to get back.

John McCain was in the middle of what turned out to be not a particularly big scandal. You may remember the whole Silverado Savings and Loan scandal -- at the time McCain seemed vulnerable to that. And he was nervous about his election. So those two guys led

this huge campaign to repeal it. Bush came in wanting to keep it. We came into the White House when there was already this huge head of steam to repeal the damn thing before we even got started. But Bush wanted to keep it, so Bill and I spent a lot of time trying to save it, and as you can tell we failed. That's one of the reasons I always felt so strongly about a drug benefit. Because I thought that was a mistake. You probably remember people jumping on Rostenkowski's car and all that stuff during the "repeal" effort.

Berkowitz:

Yes, in Chicago.

Scully:

Yes. It was a big deal, and it got repealed over my very prone body, and over Bill's. We were not happy about it, but it really got a head of steam, largely led by Bill Archer, who I like, and McCain. I think it was largely all politics. It was actually a pretty good policy, but I don't think it was vetted quite enough, and I think it was kind of run through by the healthcare policy guys, and it was probably too big a change to pass without broader debate outside the committee. It was done quickly in '88.

Berkowitz:

And can I ask you also if you think that Bush 41 had some sort of consistent social policy? He talked about compassionate conservatism, and other somewhat vague things, but was there a George Bush approach to domestic policy?

Scully:

Yes. He had a lot of consistent things about policy. We spent a lot of time trying to save Catastrophic, which he failed on. The second big thing we did in '89, which he doesn't ever get credit for, was physician payment reform. It may or may not have been a good idea, but healthcare spending on the physician payment side was out of control. I can't remember the numbers, but physician cost inflation might have been three percent, annually. Physician payments were going up at nine percent. So, we did a compromise. The RBRVS fee schedule was a compromise President Bush personally worked through Rostenkowski and the Democrats. Democrats wanted to do something to control Part B spending. We obviously, as you can guess, were not huge fans of price setting, but that was the situation we had where nothing was going to change and the old "cost" system was even worse. It was a bi-partisan deal between Bush and Rostenkowski and Benson to come up with this cap on physician spending, and put in these targets, which passed in '89. And that was a pretty intense deal. The AMAs hated it and opposed it from the beginning. It passed in '89, and it was put in place in '93. And it worked pretty well for the first six, seven years.

I would argue that the problems started in '97 during that big budget deal when the hospitals got cut heavily, and the nursing homes and everybody else got some big cuts. The physicians came in and said, "Don't cut us. Don't cut us. We're going to contribute our budget savings by tightening up the RBRVS formula." That is how it became the SGR (Sustainable Growth Rate), and nobody ever talks about that. They screwed themselves with that thing. They tightened the formula so badly that it blew up.

You didn't have these automatic cuts until I got to HCFA in the winter of 2002. We actually had a 4% cut in 2002, but after that nobody ever had the guts to enforce them and there was a "temporary fix" every year after. But the AMA, basically, took all the flexibility out of the formula. So, I would argue that RBRVS wasn't perfect, but it worked okay for the first few years. It wasn't until '97, and the aftermath of that that it really melted down.

Berkowitz:

When you talked about this to the President, or if someone talked about this to the President, did he comprehend what was going on?

Scully:

Totally. Absolutely. He was very involved. Sununu, who was the Chief of Staff, was very involved. Bush was very involved. These were big, big budget deals and tough policy calls. Some would argue we lost the election over the 1990 budget deal.

I did all the Medicare-Medicaid stuff. Dick Darman did the global negotiations. We had a guy, Bill Diefenderfer, doing the tax stuff who was the OMB deputy. The budget deals, I would argue, had a lot to do with the solid economy for the next 10 years. Certainly, Clinton did some tough budget stuff also. Much of the budget deals involved healthcare policy. And Bush was very involved in all those detailed policies. He was very involved in the RBRVS stuff. He was very aware of all this.

Berkowitz:

He could analyze numbers?

Scully:

I don't think any President's job is to sit around and go through the CBO (Congressional Budget Office) scoring tables, although they look at them. The President's job is to understand the broader policy and what you're trying to do. And he certainly spent a lot of time talking to Rostenkowski, who he was very good friends with, and Senator Bentson, whom he knew very well, and had a pretty good relationship with and others to make sure these things happened.

Berkowitz:

The Americans with Disabilities Act of 1990 has been cited as one of the real solid achievements of the Bush administration. Is that something that you were involved in?

Scully:

I was a little bit involved in that. Bush was very involved in that personally. Boyden Gray was very involved in that personally -- he had a disabled family member, I think. Boyden Gray and Tom Harkin, Senator from Iowa, and Bush were very involved in that jointly. For some reason -- I can't remember exactly why -- Boyden was very involved when he was the White House counsel. Boyden and Senator Harkin drove it.

I would argue that the biggest thing that Bush really drove, in my opinion, that nobody ever gives him credit for is the child care program. I was very involved in that. Back in '89 and '90, when that whole budget deal was going on, probably the biggest issue of social policy was that the Democrats wanted a big child care program that looked like Title One

education grants and was going to be run through local school districts, and Republicans wanted vouchers for public or private day care centers.

There was a huge philosophical fight about it. The Democrats controlled both houses of Congress, and they passed fairly liberal bills in both houses of Congress. We went in quietly over the course of probably three months and worked out a deal that was never in either bill with Chris Dodd in the Senate and with Representative Bill Ford in the House. We came up with a hybrid which is still the Child Care Development Block Grant. We changed the name from vouchers to certificates, so it looks more like Pell Grants. It's individualized vouchers for kids to get child care and it's probably a \$20 billion a year program now. It's a program that is a little bit more regulatory than Republicans wanted and more voucherized than Democrats wanted, but it's a child care program that has now worked very well for 25 years. Bush never gets any credit for that, but he should.

Berkowitz:

That's a theme isn't it? This was a President who actually did a lot of things that he doesn't get credit for?

Scully:

Yes. I have a good sense of that in this instance because I was the guy doing the work on child care with Sununu, who was the Chief of Staff. Sununu was very involved, to the point of redrafting the language on the phone with me every ten minutes. Bush was very, very, very involved.

Bush was very interested in improving services to low income people. He was not very interested in subsidizing ineffective services or wealthier people. He was trying to find a way to improve child care, food stamps, child services, and other low income services, including Medicaid, but was not interested in subsidizing people higher up the income stream. I think that was probably a theme.

Berkowitz:

So the Bush administration ended, as we know, and Bill Clinton was elected. As I understand it, you went back into private practice for a little while after that?

Scully:

Yes. Nancy-Ann (DeParle) took my place, by the way, at OMB. When I left, and President Clinton won, I remember talking to Nancy-Ann, who took the job that I had at OMB in the White House, and took over my staff so we swapped jobs twice—at OMB and HCFA.

Berkowitz:

That turns out to be fairly important job, for understanding about healthcare, and about other social programs.

Scully:

I was actually offered the HCFA job in '92 and I turned it down, because I couldn't imagine leaving the White House. At that point I was the Deputy Domestic Policy Advisor, and the Associate Director of OMB -- I had two overlapping jobs.

When I was at the White House, Gail (Wilensky) was running HCFA. We were very good friends -- did a lot of stuff together. Bill Roper left after about a year, and so for the next two and a half years, Gail was at HCFA. She came in about a year into the administration. I was in the White House and we did everything together, and she's great and I love her. She's wonderful. Secretary Sullivan's a wonderful guy, but we kind of worked around him a little bit.

Gail was really good, and everybody in the White House liked her, so we did a lot of stuff directly with Gail and things got a little tense. At some point -- it's another long story -- John Sununu got fired as Chief of Staff in the White House. Sam Skinner, who'd been Secretary of Transportation came aboard in January of 1992 and wanted his own healthcare staffer. He and I were friends. I'd been his transition aid. He wanted his own health staffer, and he said, "Look, you work with Darman. I've got to have another person in here" -- because they didn't get along at all. That's another long story.

So Gail came over to the White House -- probably in March or April of '92-- and was there until the end. We worked together very closely. But when she left HHS, Sullivan called me up and asked me if I could go run HCFA. My reaction shows how naïve I was. I thought, "Why in the world would I leave the White House to go run this agency?" I would have to call and ask Gail for permission to really do anything. So I turned the job down, which I regretted for the next eight years.

[laughter]

That is one reason I went back to do it. Because I didn't realize at the time the millions of little policy details at HCFA that were going on that I never really understood. When I had the opportunity to do it again eight years later, I realized I should have done it in '92, and there's just a whole level of healthcare policy around HCFA that I was only remotely aware of when I was in the White House at OMB, if that makes any sense.

Berkowitz:

You were talking about Secretary Sullivan. Do you think that one of the reasons it was hard, somewhat, to work with him was that he was a physician himself, and head of a medical school, and saw the healthcare system in traditional ways?

Scully:

No. He's a lovely guy who did not have a lot of political experience. He couldn't be any nicer, but he really wasn't into the policy weeds. He was a big public health guy. And he had a staff, a lot of whom I like still, who were overly turf conscious. Almost every social policy issue we dealt with in the White House was Medicare and Medicaid. That's where all the money was. That's where the policy was. The White House is always involved.

There's no reason when you're in the White House -- when you're trying to figure out what to do -- to go through 15 layers of bureaucracy. So if we needed something we just worked directly with Gail, and that drove Sullivan's office crazy. Over the course of a couple years -- this is going through budget deals and other things -- whenever we needed something at HCFA we'd just deal with Gail. They got very turf-y about it, and it got unpleasant [laughs].

I think that probably happens a lot with HHS. Doctor Sullivan himself couldn't be a nicer human being. I still run into him occasionally. He's a wonderful guy. But he didn't know the policy stuff well enough to sit around with you and add substantively to the discussion.

The example I think of is around the Bush health care plan. If you look back at the 1990 George Bush health care plan, it looks shockingly like the Obama plan, if you go back and read it. I may have the only copy left. We wrote a very detailed plan, probably in the spring and summer of '91. It looks structurally a hell of a lot like the Obama plan with a lot less money. It was basically individual mandates, and exchanges, and all that stuff with subsidies to far, far fewer people than the Obama plan.

Due to some politics, and some other things going on, we didn't roll it out until probably January of '92, which is too late. The ship was already sinking. But we had it finished probably in the summer of '91. A lot of that was done with Dick Darman and me and Gail. The HHS guys would sit around in these meetings, but they just didn't know the policy well enough to add anything. So after a while we just didn't bother and we worked with Gail. Eventually Sullivan's staff forbid her to talk to us so eventually she left and came to the White House.

Berkowitz:

In 1995 then, you went over to the Federation of American Hospitals?

Scully:

We lost the election and I went to Patton Boggs for two years. My biggest client at Patton Boggs was the Federation. I was the outside counsel.

Berkowitz:

And now you know a lot more about healthcare.

Scully:

Yes. I had been doing healthcare policy -- probably 90 percent of what I had been doing for four years. I went to Patton Boggs, did 100 percent healthcare for two years, and I was the outside counsel of the Federation. The guy who'd run it for many years, Mike Bromberg, had a heart attack. They called up, without a search, just called up and asked me if I wanted to be president and run the thing, and take his place, which I did in January of '95, until I went to CMS in 2001.

Berkowitz:

What was your big issue at the Federation of American Hospitals in your era?

Scully:

There were a lot of them. But basically the issue was reimbursement -- they are all the big investor owned hospital chains. The biggest issues were budget deals. There was a big one in '95 that got vetoed. There was a big one '97 that went through. All those had a huge impact on the hospital business and all healthcare systems.

Berkowitz:

And your job was to monitor that, and to meet with the people on the Hill?

Scully:

Yes and no. The Federation is a multi-company association with all the big hospital companies -- HCA (Health Corporation of America), Tenet, and Health South. None of them at the time -- and still largely today -- had a Washington office. They basically did everything from the Federation. So the Federation was essentially a multi-company Washington lobbying and policy shop.

Berkowitz:

Is that something you liked doing?

Scully:

It was fun. They were great. But after six years of doing very narrow intense hospital issues -- it's like watching the movie Groundhog Day [laughs].

Berkowitz:

Things start to repeat themselves?

Scully:

They repeat themselves. You wake up in the middle of the night saying, "Market basket minus two," sometimes.

But I enjoyed it, and I'm still friends with many of them. They're very solid companies and a lot of the people are still around. My current partnership, Welsh Carson, has owned a couple of the chains at various times, and I'm still on the board of two companies that were Federation members back then.

Berkowitz:

Let's talk about the second Bush era now. Were you involved in the 2000 campaign?

Scully:

Not really.

Berkowitz:

So you were still working for the Federation of American Hospitals at that time?

Scully:

I was at the Federation. I really was not involved in any way. I didn't really know George W. that well, and wasn't really involved in the campaign, and really didn't have any interest or intent in going back in.

Berkowitz:

So that raises the question of how you did come back in and become the head of HCFA?

Scully:

Totally by accident.

Berkowitz:

Can you tell us about that?

Scully:

Yes. I was running the Federation. I didn't have any intention to go back in. I don't think anybody really knew who the President was for most of December that year. I certainly didn't have any thought of going back in, but once it was declared that Bush was going to prevail, they began to bring in some people. I like President George W. a lot. He's a nice guy. I didn't know him very well until then, but he really did not bring that many people. In fact, they seemed to make a pretty concerted effort to avoid bringing people from the father's administration, because the perception of his father was that he was too moderate, and I think George W. tended to bring in more conservative people-- not necessarily in health care but in the rest of the world.

I don't think there was really a lot of discussion about who's going to be running HCFA until he already came in and was in place. It was probably early January, and by then Nick Cato -- our old friend from Bush one -- and a couple of them had gone back in, people I knew pretty well. I had a little bit of an itch to go back in, but didn't think about it too much. The two people that were the leading candidates to be the HCFA Administrator were Bobby Jindal and Ruben King-Shaw. Bobby Jindal is now Governor of Louisiana; he'd been the Executive Director of the National Bipartisan Commission on the Future of Medicare, the Medicare Commission. He was being pushed very hard by John Breaux, who's a great guy, but a Democrat from Louisiana. Breaux was personally pushing President Bush pretty hard to pick Jindal. Ruben King-Shaw, who ended up being my deputy, was Jeb Bush's Secretary of Health in Florida. So others were pushing Ruben. Tommy Thompson was picked as the Secretary of Health. And I think, to be honest with you, both of them pushed Thompson too hard to get the HCFA job

Berkowitz:

What does that look like in insider terms -- they pushed too hard?

Scully:

Well, they were both mounting campaigns to be the HCFA Administrator, and having a lot of people calling everybody in the White House, and everybody that was on the transition, and calling Tommy Thompson. Thompson had gotten picked to be the HHS Secretary, and I think he got a little annoyed that he was getting pushed too hard to pick one or the other. I ran into him at a dinner, and a friend of ours, a mutual friend said, "You ought to get Scully to do it."

I was somewhat interested, but I had assumed that I wasn't even going to be in the ballpark. I think I went in to see Thompson a couple of days later, and I think he was interested in having his own candidate, and I was a lifelong Bush guy, who had plenty of Bush credentials, so it was easy for me to be a compromise. So I basically became Tommy Thompson's candidate. Even though I didn't know him before, I think Thompson wanted his own candidate. He went to the White House and said, "Hey. I want my own guy, and I want Scully." And since they knew me, and I'd been around for a long time, it was not a hard thing to pull off.

Berkowitz:

So you went over to CMS and you got confirmed --

Scully:

Remember it was HCFA when I first got there. So I got nominated, and I was over there as a consultant for a couple months after I quit working at the Federation in March, probably, of '01. I sat around and listened to meetings and observed for a couple months.

Berkowitz:

Can I ask about your confirmation -- was it helped by the fact that you'd been hanging around Capitol Hill in your previous work?

Scully:

Yes. And I was helped enormously by the fact that I was very good friends with Senator (Jay) Rockefeller (D-West Virginia), who was my primary sponsor. I'd spent a lot of time with him in Bush-1, and with a lot of Democrats on the Finance Committee. President Bush Senior was a very bi-partisan guy. We had very friendly relationships. In the first Bush administration the Congress was overwhelmingly Democratic and things got testy, but we had very good personal relationships on the Hill. A lot of the Democrats on the Finance Committee I knew really well, and they were personal friends. Senator Rockefeller in particular I think introduced me at my hearing and really made it very clear that I'd have a lot of Democratic support. I think Senator Bentsen was still the lead Democrat. I had almost more support from Democrats than Republicans. I think they were concerned that they going to get some very conservative guy in there. I think most of them were happy that I was coming in, and Rockefeller was my number one cheerleader. I still love him; he's a great guy. So I got confirmed 100 to nothing, believe it or not. It was not particularly controversial.

Berkowitz:

Wow. While you were at HCFA, the Medicare Modernization Act was passed in 2003, and you had a lot to do with that. Could talk to us a little about that? Was that a continuation of the 1988 legislation, or what was on your mind at the time?

Scully:

I always thought the repeal of the drug benefit was wrong, and that should not have happened. I had thought for a long time about getting a drug benefit passed. Probably for the ten years, the number one issue in health care policy -- people tend to forget now -- was a drug benefit. Democrats pushed very hard to get one, and that was probably their number one political issue. And Republicans didn't necessarily have an answer. Most Republicans wanted to ignore it. Most Democrats thought it was a great political issue. I just thought it made sense to have a drug benefit. We had to have one that was market oriented. I thought it was a good substantive issue, but I also thought it was good politics for Republicans to get it done in a market oriented way, and take it off the table. And it was also the right thing to do.

The thing I told Thompson I really wanted to do was fix Medicare Plus Choice (the earlier version of Medicare Advantage), which was a mess back then, and design and push through a Medicare drug benefit. He agreed and fortunately thought that was a good set of

priorities. I think I made a list -- I can't find it anymore, but I made a list of the twenty things that I wanted to do, and gave it to him. I think we tried to do all of them. The top two were fixing the Medicare Plus choice and doing a Medicare drug benefit. Fortunately President Bush agreed, and Karl Rove and other people in the White House thought it was a good idea.

I came in May and we started working on a Medicare drug benefit. I can't remember, but I believe in June or July we announced the drug discount card to great skepticism. I'm trying not to sound partisan, but most Democrats attacked us for, "George Bush isn't serious about a drug benefit. This drug discount card is just a fig leaf." But we were pretty serious from the beginning, and we were trying to find a way to get a bridge to the actual drug benefit, because it was going to take a few years to get that done. I think we rolled the discount card out in July -- if I remember -- in the Rose Garden, about two months after I got there.

Then we get sued over whether we were exceeding our authority under the law. And then 9/11 happened and for the next six, eight months any policy other than anything related to 9/11 got pushed to the very back burner.

We rolled out -- I think it was within two months -- a whole bunch of things including hospital quality measures and quality reporting. I had a long laundry list of things to do. We did them all pretty fast, and I'm pretty sure we did the drug discount card in July with Bush announcing in the Rose Garden. Bush was on board from the beginning, and Rove was on board from the beginning, but then 9/11 happened, and as you can imagine, everybody was totally focused on that for quite some time.

That basically took all of 2001, and probably half way through 2002 we came back to thinking about designing a drug benefit. We were still fighting over the drug discount card, whether it was legal or not. But we spent a lot of time in the summer of 2002 working on this. Mark McClellan was still in the White House, so Mark was pretty involved. Mark left and went to FDA at some point. I can't remember when Mark left, but Mark left and Doug Badger, who's a great guy, came in to the White House. Mark was involved probably in the first 25 percent of it -- the beginning of it. And then I believe he left and Doug Badger came in. It was basically me and Doug Badger with Tommy Thompson. We designed Medicare Advantage reforms -- Medicare +Choice reforms. We changed the name of it. We put in the name Medicare Advantage, which we stole from Oxford Health Plans by the way. We borrowed their name.

The goal was to modernize the Medicare managed care system and put in a drug benefit. We spent most of the fall of 2002, and the winter putting that together. We probably had 15 meetings with Bush between November and the roll out, probably the following February. We went through every painful detail and were very involved with President Bush about the design and how we're going to do it, and who we're going to present it to. It was very, very controversial at the time.

Berkowitz:

How would you present this to him? It looks like an expansion of Medicare in a big way which might induce caution in the White House.

Scully:

Well, but you got to realize at the time, Bush had just done a big tax cut. There were huge surpluses as far as the eye could see. This was all before the war. So, you're sitting in the White House making policy calls in 2002, and you've got a massive surplus. You already had a big tax cut. You're not going to get another one. What are you going to do with the surpluses? I believed the right thing -- and I made these arguments -- the right thing to do policy wise is to come up with a market oriented, fairly conservative, fairly cheap drug benefit that will cover poor people.

Democrats, you remember, wanted to spend 1.5 trillion or so; their original bills were like 1.5 trillion, 1.6 trillion every ten years. So we said to President Bush, "The right thing to do is to have a drug benefit for low income people in particular. And we ought to do it in a conservative, market oriented way, so we're not having the government fixed prices." He wanted to do it for a lot less money than the Democrats. And, if you're being perfectly blunt, the argument was: It's the right thing to do; it's also good politics. This has been the top issue for Democrats for over 15 years, 20 years. We have an opportunity to come up with a Republican, conservative, market oriented plan that's focused on low income people. We ought to do it and take it off the table. You can argue there was a big expansion of entitlements and a lot of Republicans still get angry with me about it. But it wasn't me coming up with it. I came up with the policy with some other people. But it was President Bush's decision that it was good substance, and good politics.

President Bush was very involved from the very beginning. He said from the very beginning, "Let's spend \$400 billion every ten years and not a penny more and I'll be comfortable with that. I don't want to do a trillion, and I don't want to do a trillion five. It's got to be within this \$400 billion budget."

So we designed it within a very specific budget from the very first day. I can tell you when we rolled it out in the spring of 2003, President Bush went through every single detail line by line, including issues like what happens to someone who makes \$13,500 dollars a year? What's their subsidy? He had lots of questions in many meetings.

So he was very involved in everything. And he made a conscious decision that he wanted to design it for \$400 billion. I explained to him back then about the actuaries. I said, "Look, our actuaries, and the CBO actuaries have different estimates. If you tell us to design a benefit that's \$400 billion under administration HCFA scoring we're going to send it to the Hill and they are going to say, 'Great. Thank you.' But then it'll cost 300 billion because they have different scoring conventions. This is all new territory."

This is the great controversy that happened later. We designed it at \$400 billion knowing full well about how different estimates would come out. We told the President, "We're going to send it to the Hill. The Congressional budget office is going to say, 'This policy you just sent us only cost 310 billion.' Then Congress is going to expand it in their own terms to make it their 400 billion. Then our actuaries are going to say, 'Aha. That costs 500 billion, not 400 billion.'" And that is exactly what happened. Does that make sense?

Berkowitz:

Yes.

Scully:

We told President Bush at the beginning. He said, "It's fine, I'm ok with it. As long as we have it at 400 billion on the CBO's terms. I understand what's going to happen on the Hill. They're going to expand it. They're going to cost it 400 billion at the CBO. And, as long as it's not one penny more than that, I can live with it."

We went through that whole year, went through lots of compromises and back and forth. We got (Max) Baucus and Breaux, and a lot of help from Senator (Bill) Frist and others. We got, I think, 12 Democrats to vote for the thing in a very partisan environment, unfortunately. We passed a bill that cost \$399 billion the day it was passed as estimated by CBO. Now, at the time, our CMS actuaries would have told you it cost 500 billion. They were both wrong. The actual cost was way below both of those numbers.

But we explained that to Bush in the very beginning. We knew exactly what was going to happen from the very beginning. We knew completely that there were a whole new set of benefits that nobody fully understood. CBO and OMB essentially disagreed by like one percent on traditional Medicare benefits, because they'd been looking at it for 40 years. When you got in the drug benefit, nobody had any idea what it would cost because there was no history. It was all guess work. And their actuarial structures at CBO and CMS were different, and nobody really knew who was right. The only one that counted under the law was CBO.

Berkowitz:

I see.

Scully:

Now the problem with the actuary was a different thing. Rick Foster's a very nice guy, but there is a whole other issue about the independence of the CMS actuary.

Once we designed the benefit, I discussed it with Rick and all the staff on the Hill knew this, Democrats and Republicans. They knew exactly what was going on. Things heated up and some Democrats wanted to take the bill down, Congressman (Pete) Stark's staff in particular. They were just looking for reasons to blow it up. They wanted to take Rick's scoring and run around the Hill and go to Republicans and say, "Look at these guys. See how much money they're spending? They're misleading you. They're spending 500 billion instead of 400 billion." And nobody really understood these things.

So I basically said to the actuarial staff, "Look. It's none of your business to be on the Hill. It's my business. We're not going to share these internal scores with anybody, and that's the way it's going to be." And by the way, I can face that issue until the cows come home, and that was exactly the right thing to do, because the people who wanted the scores that said it was 500 billion internally, were doing it to try to defeat the bill, and had nothing to do with policy. They were doing it for purely political reasons.

Everybody knew we had those internal scores. The staff from the Hill all knew we had those internal scores. The only score that mattered was the Congressional Budget Office

score. And that score never went above \$400 billion and we would never have signed anything that went above \$400 billion. We had these internal scores from HCFA, the actuaries, which were equally as credible. They just weren't the ones that counted. The only people who wanted to make a big deal out of that at the time were people who were going to try to stir up Republicans to be against the bill. That makes sense?

Berkowitz:

Yes.

Scully:

The guys who were running around trying to blow up the bill were the guys that really wanted to spend 1.5 trillion. They were running around trying to blow the bill up just because they didn't like the fact that it was Bush's bill. There were some people on the Democratic side like that; it's just the way it is. You can say the same about Republicans of the ACA (Affordable Care Act). There are some people who for purely partisan reasons wanted to blow the thing up, and they were looking for any ammunition they could find. The bill passed the House by one vote. So, some of the Democratic staff were running around trying to get scores so they could go out and get conservatives all riled up about this bill spending too much money and have them wave the flag and vote against the bill.

The bill passed. It was \$399 billion. It was signed on December 8, 2003. I left in the first week of January 2004. I was sitting in my office in New York in March when the President's budget came out. Maybe I should have anticipated, but the President's budget came out, and it had the HCFA scores in it. All of a sudden every newspaper in the country said, "Bush lies about the cost of the Medicare Bill. It's 500 billion -- whatever it is -- 510 billion, not 400." The reality is it never changed. It was always 400 under CBO, and this whole difference in scoring conventions had been going on for two years.

Berkowitz:

Is the Congressional Budget Office if you're in HCFA or the White House -- is that really like a fortress?

Scully:

No they talk to each other. You can talk to them. The HCFA actuaries and the CBO people talk to each other. Generally, as I said, on most Medicare-Medicaid spending -- because they've been tracking program spending for forty years -- they agree on most things. They talked about scoring conventions for drug benefits, but they disagreed.

You're making huge guesses. Nobody'd ever paid for drugs before; no one really knew what the utilization would be and so forth. One of our big bets on the design of Part D was that we were going to drive people to generics, which we did in a very big way. I think under Part D the Medicare generic utilization doubled over the first five years. That was not an assumption that the actuaries made. So there was a lot of guess work. Who knows who was right and who was wrong? It turns out that they were both wildly high on the expenses side. Drug payments were way under the CBO estimates, and probably less than half of what the HCFA estimates were.

Berkowitz:

Is the CMS actuary someone that you can talk to about these things, or is the actuary sort of walled off from the rest of the agency?

Scully:

The history of the actuary thing is a bit of a story. Rick Foster's a very nice guy. I knew him when I was in the White House. He was working for Gail then as the HCFA actuary.

I walked in the first day, when I got confirmed as CMS Administrator, and all the Senior Staff came to say, "Hi." Rick walked in the first day and said, "Hi. I'm Rick Foster. I run an independent part of HCFA called the Actuary's Office." And I said, "Well, that's great." Then I went back and talked to the General Counsel who was a career person. I asked her, "What's the deal here? They're not independent are they?" She said, "Oh. This has been going on for years. During the Clinton administration, when the Republicans on the Hill couldn't get information out of the Actuary's Office, they put language in reports that said the Actuary's independent. The Actuary's not independent. He's part of the executive branch. And Rick is always running around saying they're independent, which is understandable. They want to be independent."

So I called Rick in -- this is the second week I was there -- I called Rick in and said, "Look, Rick. I understand your argument, but this is just meaningless committee report language. You're part of the executive branch. You've got to be part of the executive branch, the legislative branch, or the judicial branch. You got to pick one. That's the Constitution [laughs]. You're not an independent agency. I'm happy to have you do scoring for the Hill, but you've got to tell me what you're doing. You can't go running around the Hill independently." And he didn't like that. So I took him to the Hill, and met with (Henry) Waxman, (John) Dingell -- I met with the committees, and ranking committee members and staff of every committee in the first two weeks I was there. I said, "Here's the deal. I'll let the Actuary's Office do any scores you want, but Rick has to tell me when he gets requests. It's not that I'm trying to keep him from doing scoring. But you can't have the President write a budget, or have any administration do anything with any financial integrity if everybody at CMS can run up to the Hill and say what they want. How can you write a President's budget if somebody in the Actuary's Office can run up and talk to whoever they want anytime they like? He works for us. You've got the CBO; we've got the HCFA Actuary." And they were all fine with that.

We went on for three years with no problem. Rick is a very good actuary, very nice guy. We had a thoroughly professional relationship. He had lots of Democratic and Republican scoring requests from the Hill for three years. He always sent me an email. I always said, "No problem." Then we got into the summer of 2003 -- we were trying to do these bills. And the Democratic staff, understandably, I think, played him, in my opinion. They played on his whole independence thing, and they kept demanding scores, because they were trying to blow up our bill.

I already told you the score keeping issue which everybody knew about. They were trying to come out and argue this thing costs \$100 billion more than we claimed. It's very technical. Nobody'd understood it, and it would have been a mess. So I tried to keep it calm until we got the damn bill passed.

Rick would have Democratic staff calling him all the time asking him for scores, and I would say, "No" initially. It actually blew up over Bill Thomas, who was the Republican Chairman of Ways and Means. It blew up originally over premium support. Bill Thomas called me up and said he wanted our internal scores for premium support, because they were better than the CBO scores. I said I wasn't going to give them to him. So he called up Rick and demanded them. I told Rick, "Don't give them to him. Bill Thomas is a good friend of mine. He'll call me up to ask for them and he knows I will not do it." And after a couple of angry calls from Thomas, Rick basically gave Thomas the scores that I asked him not to give Thomas. I never threatened to fire him, but I was more than a little bit pissed off.

Berkowitz:

You know there's history of that, too. There's famously this actuary at SSA that was fired.

Scully:

I didn't fire him. I told my Chief of Staff, who was also a career guy, "I'm too mad to even talk to him. You go." His email to Rick ended up in a full page thing in the *Wall Street Journal*. It was a big blow up. He basically said, "Your actions are inappropriate, and if you don't cut it out there'll be severe consequences."

I never threatened to fire Rick. I actually got along with Rick fine. Rick thought I was sitting on him, and I was. That was my appropriate role. I thought the Democratic staff on the Hill -- who were trying to defeat our bill -- were playing him. They were playing on his desire to be independent, using that to get to a political argument to get misleading information to kill our bill. Everybody knew what was going on. There's no great mystery about it.

Berkowitz:

So, what is the solution to this? An actuary is a peculiar thing. Is the solution to have just a HCFA budget office that would be part of the agency?

Scully:

No. The answer is that the CBO does Congressional estimates. The HCFA actuary works for the executive branch; the CBO actuary works for the legislative branch. That's how it should work.

Rick was effectively pretty independent, but he's part of the executive branch. The problem here was you had a totally new program with no historical experience, and the actuaries in the two different departments didn't agree on the scoring conventions, and people were trying to use that for political reasons. And I was trying to avoid that.

Rick was not a political guy. Rick had this belief, "I'm an actuary and I'm independent," which is understandable from his point of view. He felt, "I should be able to go out and say whatever I want." Well, the fact is the structure of the Constitution says you work for the executive branch, or the legislative branch, and I had this debate with him.

At the time it was very pleasant, by the way. We didn't have any big fights. I just said, "Rick, you can't go to the Hill and tell these people stuff; the only people that are calling

you on the Hill are the ones that want to stir up trouble -- people trying to use this to defeat the bill. It has nothing to do with substance.”

When we passed the bill by one vote in the House, Stark’s staff person, whom I had a pretty good relationship with before that, called up and insisted that we give her the scores. I said, “No. We’re not giving you the scores.” Then she called me up at midnight at home and said, “If you don’t give me the score I’m going to have Rick Foster up tomorrow morning and have a press conference.”

I said to her -- and this is the only time I ever said anything like this, I was angry and I said, “I’ll fire him so fast his head will spin.” And so the next morning at nine, which I thought was totally cheap shot, because I had a pretty good relationship before that, they put in a press release from Chairman’s Stark’s office saying, “CMS Administrator threatens to fire his actuary.”

That was the only time that I ever said anything like that to anybody. And I never said it to Rick, and I got along fine with Rick. Anyway, that went away. We passed the bill. The whole thing went away. The bill passed. Everybody was relatively happy. I think it was perceived to be a great success when I left in December. And, then, I was sitting in my office the next March, and all of the sudden the budget comes out and it was an election year, and the people on the Democratic side, understandably, were teed up to make a big deal of it. And, all of a sudden, every newspaper in the country said, “Bush lied about Medicare budget, drug benefit \$100 billion more than he said three months ago,” which was completely contrived.

But it blew up into a mushroom cloud and I had to go through six months of stuff and magically it went away the day after the election. But, anyway, that happens, and I understand.

Berkowitz:

It’s interesting that there have been these issues before, and they’re always about the beginnings of programs. How much is disability insurance going to cost? How much is Medicare going to cost? So this is another one in that tradition.

Scully:

Yes. Although, this is, I would argue, the only major new entitlement that came in at half the original cost.

I think the reason is -- in my humble, biased opinion -- that it was market oriented. It was designed to drive competitive pricing and generic utilization. I think the donut hole was put in there intentionally, and it was intended to heavily subsidize poor people, and not heavily subsidize wealthier people, and make wealthier people more significantly sensitive to the cost. I think closing the donut hole is crazy. It was designed to do exactly what it’s doing. Thirteen million low income people had no co-payments, no deductibles, and essentially, at first, all coverage for drugs.

You can debate, just like you can do on the ACA, how far you want to go up in the income stream to subsidize people. I personally, was never a big fan of subsidizing millionaires to

buy their drugs. We did, but closing the donut hole just makes no sense. I think the benefit was designed reasonably well. It was the work of an awful lot of compromise with Senator Baucus, and Thomas, and us, and John Breaux, and a lot of other people. I think it's worked reasonably well.

Every presidential election year people -- unfortunately, in both parties -- look for whatever bomb they can throw at the other guys. And I -- unfortunately, for that one year in 2004 -- I happened to be one of the bombees.

Berkowitz:

I want to make sure I ask you about the name of the agency which changed from Health Care Financing Administration to Centers for Medicare and Medicaid Services in your time. I don't know if you had anything to do with that or not. Did you?

Scully:

Yes. We did it 100 percent. It was one of the twenty things I gave Tommy Thompson that I wanted to do.

I love Nancy-Ann. She's very good, but for whatever reason she had to spend a lot of her time the last two years on Y2K. Having been there running the Hospital Association, I think she's very good -- was a great HCFA Administrator, but for whatever reason the general perception was that HCFA had become perceived to be slow moving, bureaucratic, very unresponsive. And most people in the health care field looked at it as a difficult place to deal with.

And I just said to Thompson, we needed to change the name. There were two reasons. One -- I said to Thompson, "I think we've got to change the perception. Changing the name helps change the perception." And the other major reason, which not many people know, is that there was a big move on the Republican side and the Conservative side to split the agency up. There were a lot of Republicans who thought Democrats didn't like Medicare managed care and wanted to destroy it. At the time I came in, Medicare Plus Choice was down to fewer than three percent of the program.

We were trying to enhance private Medicare because fundamentally Republicans don't like administered pricing and price fixing. So we were very intent on getting more people in capitated private protocols, which I think is now the more bi-partisan view. But back then it was not. Anyway, conservatives were pushing for splitting up HCFA into three different agencies and having a managed care agency, a Medicaid agency, and a Medicare fee for service agency because they were afraid Democrats were trying to kill Medicare managed care.

I knew that the agency was held together -- at least on the IT side -- by baling wire, and splitting up the agency was crazy. It was having a hard enough time running the programs as it was without splitting it up. It just functionally didn't make any sense. So, I said to Thompson -- who I love, he's a great guy -- I said, "We got to change the name number one to give the impression that we're doing fresh new stuff, and number two because we need to tell the right that we're creating all these new centers to protect the parts of Medicare they like."

The most popular part of HHS was the Centers for Disease Control, I argued. So, why don't we come up with something like that? I was trying to come up with something that had three centers. So it'd sound like that.

We basically didn't change anything. We declared that we had three centers: a Center for Managed Care, a Center for Medicaid, and the Center for Medicare. And we declared we were adopting the conservative point of view so we're restructuring the agency to protect Medicare Plus Choice, and re-scope it as Medicare Advantage. That was one target, to keep the right off our backs. The other was to just have a little bit of a fresh start from some of the baggage that HCFA, fairly or unfairly, carried.

I checked around. There was nothing in the statutes. HCFA was made up by Joe Califano. There was nothing in the statute, so I sat around with Tommy Thompson and we came up with names. We had probably thirty names. The first one we picked was MMA -- Medicare and Medicaid Administration. Then we ran some test groups on that and the acronym was MaMA --

[laughter]

He liked that one, but I convinced him that would not be very popular with half the population. So we dropped MaMA, and I came back a couple days later with CMMS, and we talked about that. I still get flak from Uwe Reinhardt for not calling it CMMS. Center for Medicare and Medicaid Services was the right name, but CMS was the right acronym, like FDA and CDC.

So we came up with CMS and some guy in the graphics office came up with the logo that was done in house. We were afraid we were going to get beaten up for the costs to implement the change. I said, "We don't have to change anything. We'll just change the name. We won't even change the name on the building, and we'll gradually change over the years when we run out of stationary, so that nobody will beat us up for cost." It was basically Thompson and me. I think it was in June of 2001.

Berkowitz:

That's interesting. I've never heard that explanation about why it's only one 'M' before.

Scully:

CMMS was just too much mumbling, so we came up with CMS. It looked better and sounded better, and so that's why it's CMS.

Berkowitz:

And it kept Medicaid and Medicare together, which is probably significant.

Scully:

I think it would have been a big mistake to break them up.

Berkowitz:

I wanted to ask you about more recent stuff, like the Affordable Care Act in which you are now an interested observer, rather than an agency head. Were you involved at all in the passage of the Affordable Care Act?

Scully:

Tangentially. I still practice law part time -- maybe a quarter of my time. So, through some clients, legislatively I was involved, but I was not intensively involved in any way. I do care about the policy.

Berkowitz:

Did it surprise you that it passed?

Scully:

I was a little surprised it passed, and I was disappointed. I think how it was handled politically was a big mistake, even though I think it will go down as President Obama's primary legacy. On the Democratic side, I'm sure that they should be very proud that they got universal coverage. I've always been a big believer in universal coverage.

I think it's a mistake, and I went through this in Part D. I think it's always a mistake to pass anything big that you want to have by a pure party line vote. A lot of my Democratic friends say, "Well Republicans wouldn't play ball." You've just got to keep going back and grinding it out until they do. I think they would have been much better off to have had even two Republican Senators go along, no matter what they had to do to get them. I know that they would argue that was not possible. Chris Jennings is a good friend of mine. And I know Nancy-Ann tried hard to get Republicans.

I understand their point, but I just think when you do policy that's this big, it's very difficult to do it on a purely partisan basis without having a 15 year knife fight after that, and it's just unfortunate. So, my fundamental problem -- and I just saw Marilyn Tavenner yesterday, who's also a very good friend. I've said this to all my Democratic friends. I think if you look at the ACA, the structure of it, with exchanges, I might have done it a little differently. Refundable tax credits, transfer payments, exchanges, universal coverage -- all those things are things that I supported for years. My problem is the level of subsidies.

I've had two fundamental problems from the first day of the ACA, and they're not the normal things you would expect. It's not a big government takeover of healthcare. The structure's actually reasonably sound, if overly regulated in the details. It's actually a privatization of healthcare, which I say all the time. It's basically a big move towards private coverage in healthcare. I might have done it a little more gently. I probably would have done some different things in the way they regulated the insurance plans and made the insurance regulations different.

The big gripes that I have about it, which I think are in my humble opinion [laughs] not refutable -- I think it's a giant mistake to go to 400 percent of poverty. I just think if you created a new entitlement program like this that goes to 64 percent of Americans it's just way over done. Most of the proposals to do this kind of thing in the last 20 years I was involved in went to 250 or 300 percent of poverty. When you get up to subsidies -- significant subsidies where people are making \$94,500 a year -- my fundamental problem

is that's a massive number of people to subsidize, and you're totally distorting the system. Some people say "300 versus 400 percent, why is that such a big deal?" the answer is that it is 50 million people getting a new entitlement.

So, my problem is not with the structure of it. My problem is that they went way too high on the income scale and the subsidy level is too great. It's a philosophical difference. Democrats like to spend more money. I personally have a big problem with subsidizing the upper middle class like that. And the second problem, which I think is really the biggest mistake, is the Medicaid expansion.

I personally am for expanding Medicaid, but it ought to be fixed first. Medicaid is a \$600 billion a year program. It is a complete disaster structurally, financially. No state really knows its match rate. They know what their official match rate is, but there's not a human being in the world that can tell you what the actual match rates are for 50 states and territories, because everybody has provider taxes and donations. It's a \$600 billion program that's built in every state on financing scams. It's not the states' fault. It's just the way the program works.

The economic incentives in the program are completely out of whack and have been for 20 years. I just think it's a very bad idea to expand the Medicaid program on a structure that's so broken. I would be for expanding Medicaid, but they should have fixed it first.

I'm on the board of the Dartmouth Medical School in New Hampshire. The state of New Hampshire doesn't put one penny into its Medicaid system anymore. It's more than 100 percent federally financed.

I think having the second biggest program in the country be run on an unbelievably irresponsible, outrageous financing system is just wrong.

Berkowitz:

Very interesting. We've taken a lot of your time, more than we had asked you to schedule so I think that that's probably a good place for us to stop --

Scully:

You want me to stop on that depressing note?

Berkowitz:

[laughs]

Scully:

I didn't give you a whole lot of history of my CMS time. There are a lot of different things we did that I'm happy about -- the comparative outcomes, and HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems), and paying hospitals differentially. All that stuff we started doing -- which people tend to forget. Mark McClellan expanded on it and the current administration's doing a lot more. But we began with the hospital quality measures, and outcomes measures, and trying to pay providers differentially. I think probably the best thing we did was drive Medicare managed care up from three percent to where it's now 31 percent. That was done pretty intentionally, just to

get people out of the administered pricing system. I think those have all been positive changes.

Berkowitz:

So, let me ask you. Where do you see this all going? Clearly there's a big effort now to not pay hospitals and doctors in Medicare just because they did something, but to somehow change that and to put in aspects of quality or efficiency, or something. Where do you see that going ultimately?

Scully:

I think ultimately if you went back and asked Democrats or Republicans 15 years ago, "What do you think the right model is at the end of the day?" The right model at the end of the day for me was always the Federal Employee Health Benefit System -- maybe it's because I was a federal employee for 16 years.

This is where the philosophical debate about Obamacare gets so crazy -- Republicans and Democrats, in my opinion get so crazy. Republicans hate Obamacare, but yet they love premium support for people over 65. Democrats hate premium support for people over 65, but they love Obamacare. It's the same thing. Obamacare is premium support, right? For people that are below 65 what the ACA is, is premium support. And Republicans are for premium support above 65. And essentially both of them are the Federal Employee Health Benefits Plan.

Once you get past the politics of everybody hates, automatically, what the other party is doing, I believe that the world's moving inevitably towards more capitation. The governors have now gotten over 70 percent of people in Medicaid in managed care. Medicare's growing in private managed care plans. I just fundamentally believe that fee for service medicine is the wrong way to go. It's nobody's fault. It just is. When you pay every doc the same thing, and every hospital the same thing, that's what drives price fixing and fee for service. Fundamentally administered pricing doesn't work. The right way to go is getting people into private plans that are capitated, that are well regulated, with the insurance company margin regulated.

I think Medicare is moving that way. Medicaid is moving that way. That's where the ACA is, and I think inevitably in 15 years you're going to have a system where everybody's in one local exchange, and based on your age and your income you're going to get subsidized, and it'll be premium support for everybody. I think that's where the system's moving. I think that's where it should move, and that's where I personally have been trying to get for 25 years.

Berkowitz:

And that'll be the ultimate end of the national health insurance discussion?

Scully:

That will never end. There's always going to be some people that think differently. I respect them. I've had many, many debates with lots of people. I'm sure you'll talk to Bruce Vladeck, who I like very much. Bruce fundamentally thinks capitalism in healthcare's evil and terrible, and all these people are gouging the system. He thinks that

the only way to do it is to have everybody in a single payer system where people at CMS set the prices.

I respect his opinion. I just fundamentally don't agree with him. I think, in the history of mankind, there's never been an economy ever anywhere that price fixing has ever worked. And I think health care is one of the worst victims of that.

My own view is the faster we can get everybody into a well regulated private health plan, the better, and that is what the ACA is trying to do. I'd do that in Medicare and Medicaid. Then the issue becomes whom do you want to subsidize, by how much? Most Democrats probably would subsidize more people than I would be comfortable with.

My view is we have to make sure everybody has coverage in a reasonably well structured plan and subsidize people that need it. My definition of people that need it is probably lower than what most Democrats think. But I think that's where the system's going. I think if you get past the politics of everything Republicans do Democrats hate, and everything Democrats do Republicans hate, the world is quietly, slowly moving to more capitation and eventually to an FEHBP like structure.

If you go to most Democrats and say, "What do you think of the Federal Employee Health Benefits Plan?" They say, "It's great." Same thing with Republicans. It's just the politics gets so tangled in all this stuff. It's crazy. Again, if you're over 65, premium support's great if you're Republican. If you're under 65 premium support's great if you're a Democrat. How the hell does that make sense?

Berkowitz:

Indeed. Thank you so much for doing this interview.

Scully:

Alright. Good. Take care.

Interview with Dennis Smith

Washington DC on May 11, 2015

Interview conducted by Edward Berkowitz

Transcript edited for clarity.

Berkowitz:

Today is May 11th, 2015, and we are at the headquarters of the National Academy of Social Insurance in Washington. I'm speaking with Dennis Smith. Let me ask you a little bit about your background. I've heard you described as someone from rural Illinois. That's true?

Smith:

Yes, a little farming town, 1,500 people.

Berkowitz:

Is it in Ronald Reagan territory?

Smith:

It is, very much so. He was born in Tampico, Illinois, and his father moved the family to Chicago briefly when he was six or seven and then they moved back to Dixon, Illinois. So Dixon is where he was the lifeguard on the Rock River and saved all the pretty women who suddenly couldn't swim, that sort of thing. And my little town of Walnut is sort of on the triangle, so it is Reagan country.

Berkowitz:

I see. Dixon also had a mental health hospital that was a big employer there?

Smith:

Very much so. Lot of people from Walnut worked at Dixon State.

Berkowitz:

So let's talk a little bit about your career, some of which I don't know about but maybe you could kind of fill me in on. You went to Illinois State, is that correct?

Smith:

Yes.

Berkowitz:

At Jackson, is that where that is?

Smith:

No, Normal, Illinois. It's Bloomington-Normal, but ISU is actually in Normal. It started out as a teacher's college, so it's probably produced more teachers than any other college, in Illinois, at least.

Berkowitz:

Interesting. You've had a number of interesting jobs, and if I read your background correctly, you worked in California -- in the California Department of Developmental Services?

Smith:

Yes.

Berkowitz:

So how does that fit in chronologically with going to college?

Smith:

I graduated from ISU, came out here to Washington, DC, in April of '79, had graduated in December. I had done an internship for Bob Michel, who was Minority Whip at the time.

Berkowitz:

And a Congressman from Illinois?

Smith:

Yes, sir, the 18th Congressional District. I applied for an internship because he was my congressman, got the internship and worked in the whip office. The legislative director was a man named Tom McMurray. Tom had worked for Reagan in California as well, and was part of his top team.

I had graduated, no surprise, with a degree in political science, minor in history, and Washington was the place to go if you wanted to do a career in government and politics. So I ended up connecting again with Tom, who had left the Hill by that time. But he had, as I said, worked for Governor Reagan and was closely connected still with Ed Meese and Mike Deaver and all of those folks. Tom unfortunately died in September of 1980, before the election, but he had introduced me to one of his colleagues, named Dave Swoap.

Berkowitz:

That's a name I do know. He was Undersecretary of HHS.

Smith:

Dave became Undersecretary -- under Secretary Schweiker at the time, and Schweiker and his team were going to do the healthcare side, and Dave and Jack Svahn went to do Social Security, Bob Carlson was over in the White House doing welfare reform, so Dave was going to lead the welfare effort. And he had asked me to help on the transition team, the Social Security transition team

Berkowitz:

This is the transition team at the beginning of the Reagan administration, 1980?

Smith:

Yes, sir. So then Dave became Undersecretary and I became his assistant.

Berkowitz:

That transition team eventually made quite a name for itself and one story is that it was advice from the GAO (General Accountability Office) and ultimately from his transition team that led to the disability reviews in the early 1980s.

Smith:

Yes, indeed.

Berkowitz:

Were you involved in that?

Smith:

In the transition work, I was the paper collector and keeping people organized and saying, "We've got deadlines," that sort of thing. The team itself was a mixture. We consulted with a lot of the career people, and got a lot of advice from them who were more than willing to say, "This is a huge problem on the disability side, needs reform." Social Security had computer problems. It would have to be, in many respects, dragged into the modern world, moving from labor-intensive paper to technology.

Berkowitz:

I see. So when you worked on the transition, I would expect that you would then have gone on to some job in the administration?

Smith:

Yes, Dave became Undersecretary, and I became his executive assistant.

Berkowitz:

Shuffling papers still?

Smith:

Well, a little bit more than that, doing some policy analysis and budget work and attending all of his meetings; I was starting to help draft some of his memos. If you remember the swap that had come out of Rich Williamson --

Berkowitz:

The swap of welfare and Medicaid?

Smith:

There was a combination of a number of different programs. The big swap was huge. It included transportation, education, all these things. Rich Williamson was in the White House, Intergovernmental Affairs. He was trying to put this grand package together, which then became smaller and smaller and smaller, as one agency or another started to object to it.

And then it became a Medicaid and welfare package. It was getting very serious discussions. But it became part of it to swap the acute care side of Medicaid for the long-term care side of Medicaid; the idea was that the federal government would take over the long-term care financing. And the numbers were just so astronomical that it sort of collapsed at that point in time.

Berkowitz:

What was the rationale for that, for the federal government taking over long-term care, which is a key Medicaid program?

Smith:

We were trying to balance numbers basically, to make it an even swap. But the liability in the out years was so enormous, plus, when you federalize rates, Medicaid would be paying Medicare rates, and those were much higher than Medicaid rates. I think it was fair to say we would have been increasing demand if the federal government would have taken it over, and at much higher rates, and of course the demographics over time.

Berkowitz:

All right. So you worked in the department that had just become Health and Human Services (HHS)?

Smith:

Yes. It had become HHS. It was after the swap collapsed, and the President and the Hill set up the Social Security Commission to deal with the DI and OASI, and clearly things were sort of drifting off in a different direction. Dave accepted a job becoming Secretary of the Health and Welfare Agency back in California. I went out to California with him. I was there '83 to '86 to help him get set up and feet on the ground, but told him I'd like to be able to get some management experience, get some greater experience on my own.

Dave and I are still friends, we still talk. He was a mentor, and I had the greatest admiration for him. But I wanted to start having a career, not just tied just to Dave. So I went to work in the Department of Developmental Services. The Lanterman Act had been passed in California at the time about de-institutionalizing the regional centers. I was part of the team working on identifying individuals in the centers who should be moving into the community, and building community supports around them.

It was a fascinating period of time, visiting the centers themselves, visiting the state hospitals. A number of the state hospitals, the buildings, were crumbling at the time, sitting on very valuable real estate in Sonoma and Napa. And so, there was quite an extensive planning project going on in terms of how to use the resources from the institutions in helping support people in the community.

Berkowitz:

Developmental services, that's for developmentally disabled -- for the people who used to be called "mentally retarded"?

Smith:

Yes.

Berkowitz:

And there were institutions that had been built to school them and house them that the state ran, and moving people out of them was part of the de-institutionalization that was going on nationally?

Smith:

Yes. And that experience has shaped so much of my views over the rest of my career, in terms of Medicaid, long-term services and supports and home and community-based living, that sort of thing.

Berkowitz:

Didn't Medicaid have restrictions on provision of aid to people in institutions?

Smith:

That's on the mental health side, but with Intermediate Care Facilities (ICFs) for Developmental Disabilities, federal funding was allowed. The per capita rates for those ICFs were well over \$100,000, even at that point in time. And as I said, the hospitals, the ICF buildings themselves, were just sinking. It was a money pit, in many respects.

Berkowitz:

\$100,000 per capita per year?

Smith:

Yes, in some of the facilities even in the '80s. Going into the institutions themselves, meeting with people, was a tremendous experience for a kid from the farm from Illinois. Remember that HCFA was the Health Care Financing Administration. We paid for care, purchased services; we don't deliver it. Being on the ground is different; it's not just a question about money. The decisions that you are making impact peoples' lives.

I remember a couple of cases. One was a young woman; I don't remember her disability. There were all different levels of needs still in the institutions back then. You might have young people who had been victims of drowning and had lost almost all of their brain function.

There was a young woman, early 20s, who had intellectual disabilities but also physical disability with her legs. The muscles had atrophied to a point that she was never going to walk. And through the process, one of the people on the staff there, he and his wife took her into their home. They worked with somebody to fix up a crazy bicycle-type contraption, and started over time to build that strength up again. Ultimately she was riding a bicycle and very normal, doing everyday things.

And on the other hand, I remember a gentleman -- he was 83 at the time -- who had mild mental retardation, but he smoked his pipe and helped out the staff, raking the lawn after the grass was mowed. He was completely, completely self-reliant, but he had been left at the state hospital as an infant, so that was the only home he ever knew in his life.

What are the ethical, moral things around all of these different individuals that you're seeing in a microcosm? I started saying it then, and I've used it for 30-some years, "You will not find the Wisdom of Solomon in the Federal Register."

Thinking of these very different individuals in one facility, how do you have a system that surrounds those individuals that is best for each one of them?

Berkowitz:

Can you find the Wisdom of Solomon in Sacramento?

Smith:

No.

Berkowitz:

Alameda County?

Smith:

No. You find it in the hearts and minds of people. You are more apt to find it at the local level than you are at the state level or at the federal level. The federal government is so far removed from peoples' lives. And, again, HCFA was a financing agency.

When I made the jump from Virginia Medicaid in the late '90s to CMS becoming the Medicaid director, a couple of things were very fresh in my mind. We had to close a couple of nursing homes that had failed surveys, and we had to deal with the staff, the residents of those facilities, the families, et cetera. One of the things that I would continually remind my colleagues at CMS about was that they were the surveyors; they were the experts. But when TV cameras were rolling, no one from CMS was explaining what was going to happen to 120 people being uprooted from their home; there wasn't anybody from CMS there explaining that.

Berkowitz:

Let me just see if I can get the chronology straight. In 1986 you left the job in California and went to the Congress?

Smith:

No, I came back to D.C. and went back into the Reagan Administration again. I was the Director of the Office of Family Planning; I ran the Title X Program. If you remember the gag rule -- Jo Ann Gasper, who was the head of the Office of Population Affairs, hired me to run the Title X side and a woman named Nabers Cabaniss to run the Adolescent Family Life Program that had been created by Senator Denton. Jo Ann ended up leaving the administration. Nabers and I drafted the rule which was ultimately argued at the Supreme Court, by Ken Starr, if I remember correctly, and won.

Berkowitz:

So that was back at HHS?

Smith:

Yes, that was back at HHS, so the election of '88 came, and George Herbert Walker Bush won. Bush 41 won, and most of the Reagan people were replaced, so that's when I went to the Hill.

Berkowitz:

You say most of the Reagan people were replaced. Was it California people, was that a particular badge?

Smith:

No. It was pretty much across the board. He wanted his own people. And, ironically now, Ron Kaufman was head of Presidential Personnel, and now he's a colleague of mine at McKenna Long.

Berkowitz:

So you went to work back in the Congress then at the beginning of the George Bush administration. And you worked for both houses eventually?

Smith:

Right, I had worked in the House first, for Congressman Tom Bliley from Richmond, Virginia. People move up because other people move on. So Bush wins with Dan Quayle as his running mate from Indiana; Quayle becomes Vice President. Dan Coats, who had been in the House and had been the ranking member on the Select Committee on Children, Youth and Families, goes to the Senate. Then Tom Bliley moves up to become ranking member on Select Committee on Children, Youth and Families.

Berkowitz:

And you were working for the Committee?

Smith:

I was the Republican Staff Director for that Committee. George Miller from California was the Chairman at the time.

The Select Committee was in some respects, kind of a think tank, and the hearings that the majority designed were very much to forward their agenda on health, welfare, social issues, that sort of thing. So it was a fascinating experience dealing with putting hearings together and having great debates on the Select Committee. They would produce reports and we would write extensive minority reports.

Berkowitz:

It doesn't sound like you found it particularly difficult to be on the minority side in this case?

Smith:

No; not at all. It was intellectually stimulating. It was policy debate. It was fascinating to go directly head on, having those debates.

Berkowitz:

How about on the Senate side?

Smith:

From Select Committee, Mr. Bliley becomes the ranking committee member on the Committee on the District of Columbia, and Congressman Dellums became the Chair of the D.C. Committee. The irony of me, this kid from rural Illinois, charged with overseeing

the District of Columbia. This is when Sharon Pratt Kelly became mayor after Mayor Barry's unfortunate extracurricular activities.

Berkowitz:

It wasn't over for Mayor Barry.

Smith:

No, it wasn't, but the District was basically broke.

The Committee on the District of Columbia was the third oldest committee in Congress; under the Constitution, Congress was still in charge of D.C. Dealing with building heights, dealing with St. Elizabeth's Hospital, dealing with all sorts of things were very interesting. But the finances -- because of the problems with the District -- that was my first real digging into financing of a municipal government, government financing. Our work ended up with creation of the Control Board. Mayor Williams became the head of the Control Board, and then he became mayor. And ironically, I am now working with him again. He's another senior advisor at McKenna.

Then the Republicans won the majority in November of '94 -- the Gingrich revolution with the Contract for America. Mr. Bliley becomes now Chairman of the Energy and Commerce Committee.

But while I had been his staff director on his other committees for six years, one of the other staff members became the Committee Director, and so I thought it was time to move on and went to the Senate with the assistance of Jo Anne Barnhart.

She had been at Social Security with Svahn and then at the Administration for Children and Families running that. It was a small group of us. Jo Anne had worked for Senator Roth on the campaign side of things, had run his campaign. She introduced me to John Duncan who was Mr. Roth's Chief of Staff. And so I went to work on his personal staff with a portfolio of the health and welfare issues.

The chairman of Finance at the time was Senator Packwood from Oregon. He runs into his own personal problems, resigns from the Senate, and Bill Roth becomes Chairman of the Finance Committee. This was right as the great balanced budget debates between the Republican Congress and President Clinton start clashing.

There was the big conference out at Andrews, trying to get the Congress and the President to work out a deal on a balanced budget. It fails.

So I'm doing welfare issues and Medicaid issues on the personal staff. Roy Ramthun, who had the Medicaid portfolio for Senator Packwood on the Finance Committee staff, decides to leave to pursue things on his own. So I move over to the Finance Committee to do Medicaid.

Berkowitz:

Oh, I see. So now you're working with Medicaid and you ultimately become the director of the Medicaid program in Virginia?

Smith:

In the Balanced Budget Act of '97, we do some Medicaid reform, and we create a little program called the State Children's Health Insurance Program-SCHIP. As we are doing our late-night drafting, one of the things that we could not get agreement on was what to call the program. The House Republicans wanted to call it the Children's Health Assurance Program, CHAP. And I said "No, we can't call it CHAP. President Carter had a children's health proposal called CHAP. We are not going to call it CHAP." So, then we come around to Children's Health Insurance Program. And at the last second, we said, "No, we're going to call it the State Children's Health Insurance Program." So that's the way it got named.

At this point in time, Kathy Tobin, who had been doing the welfare issues side of things, and had been there since Senator Packwood, and stayed through Senator Roth -- she leaves. Now, in the BBA, I'm doing the welfare issues and the Medicaid issues.

When we did the Personal Responsibility and Work Opportunity Act, PRWORA, of '96, I'm there negotiating with the House. I'm doing that work. I was just tremendously blessed to be able to do those things. But by mid-'98, I was just absolutely exhausted. I got a call from Jim Gilmore who had been the elected governor, the first Republican governor since Reconstruction in Virginia. David Anderson, whom I had hired to work on the D.C. Committee -- he had gone to work for Mr. Gilmore as Attorney General. I got a call from David saying, "Would you be interested in coming and working in the administration?" So I went down to Richmond and ran Virginia Medicaid.

Berkowitz:

You moved to Richmond?

Smith:

Well that's a different story. I ended up commuting to Richmond.

Berkowitz:

Would you recommend that?

Smith:

I'm not certain how I survived that commute. We couldn't get our house sold in Northern Virginia, and I couldn't afford two mortgages. So the kids went back to their schools up here and everybody was happy about that. But I took a long commute.

Berkowitz:

What years were you in Richmond?

Smith:

This was '98 to the Bush-Cheney years. In BBA 97 I just helped create SCHIP, so now I was going to help implement it, which became great lessons for the implementation of the ACA. There's policy and there's the execution of policy. You learn an awful lot being able to do both sides of it. We did that, expanded managed care, had done an MMIS (Medicaid

Management Information System) procurement, and were dealing with Y2K. There was a lot going on in a very short period of time.

Berkowitz:

From the state of Virginia's point of view, what was the problem with SCHIP, in terms of implementation?

Smith:

In the previous administration there had already been a budget deal to do just a straight Medicaid expansion. We revised it to be a separate SCHIP program, and we wanted to create a separate program using managed care as platform. I convinced the governor and the leadership and the legislators.

This was my bias and something that I learned over time -- that kids actually don't go down to the local welfare office all by themselves looking for insurance. The chances are if the kid is uninsured, that the parent is uninsured. So I convinced people we ought to be insuring families. This is not just a child issue, it's a family issue. So, we created the Family Access to Medical Insurance Security Program, FAMIS. And that's what it's still called today, in Virginia.

My thinking was that if you are a family at the poverty level your income was higher than the Medicaid eligibility. But, trying to buy insurance on your own was still a pretty pricey situation. So the idea was that extending coverage for the family would be a better approach.

Berkowitz:

I see. So you say that you tried to do managed care. What's the philosophy behind that? Is that something that's cheaper?

Smith:

Managed care had started in the Tidewater area in Virginia, in Norfolk.

To go back for a second -- we've implemented FAMIS, and we were keeping track by county of enrollment. We're looking at the numbers across all of the counties in Virginia. And the first region to come right out of the box was southwest Virginia -- rural, conservative, et cetera. And we're saying, "Those numbers are so high, and they happened so quickly. Why was that?" Well, families had come in having previously applied, and they had a little too much income. So their kids hadn't been eligible for Medicaid. The county workers -- at that level you're not just a county worker, you're a neighbor, you know these people personally. The county worker kept the applications on file. Then they call them up and said, "Dennis, we had to tell you 'no' a month ago, but now we can tell you 'yes' because of this new program."

Berkowitz:

We used to call that street-level bureaucracy.

Smith:

It's personal, it's local. And so, the numbers went up right away in southwest. In the Tidewater area, which was on an income level lower than much of the rest of the state, we're figuring out, "Why such a low uptake rate in that area?" Well, they're lower income, but they're actually insured, because they were military families. So the kids had coverage through mom or dad through the military.

We learned an awful lot about outreach and enrollment and what really brings somebody to get someone enrolled. We studied these things; we had the experience of it. Some of our best recruiters were local priests at the Catholic Church, who told their Hispanic community, "Yes, you will sign your kids up for this program." There are people in the back of the church to help; "when you leave mass today, you will go sign your kid up."

When the government starts offering money for an implementation program, you get people who show up in droves saying, "I know how to spin that for you." They want to do bus advertising. McDonald's wanted to put an insert on their tray. And everybody wanted to spend the government's money. And, for the most part, that's not what's effective. It's that local, personal identification with somebody you trust that works.

Berkowitz:

Interesting. So, then you got to the Bush-Cheney transition. In that election, did you work for soon-to-be President Bush?

Smith:

No, not at all. As a political appointee, I always thought it was inappropriate to do campaign work -- just for me personally. I know other people say, "Well, I'm volunteering on my personal time." I always felt for me there's just not going to be any question whatsoever that I've ever used any public resource to work on a campaign. So I just don't. So, no, I didn't work on the campaign. I didn't do anything. I got a call after the election.

The Bush-Gore election had the hanging chad issue and wasn't decided until early December. At the end of that week, I got a call from a former colleague that I'd worked with on the Hill, who was on the Bush team and was running the transition. She said, "Dennis, you're about the only one that we know who's ever been in the Humphrey Building (headquarters of HHS in Washington). Would you come and run the HHS transition team?" So I did that.

It was a tremendous opportunity; transitions are very fascinating. I had done the Social Security transition, but to run the entire transition for the whole agency was tremendous. The Clinton administration wouldn't tell us very much. And in fact they had regulations in the pipeline that they were ready to finalize. These were very controversial regulations, such as the Medicaid managed care regulations. And they refused to give us any information about it -- where it was in the decision making process -- that sort of thing. So it was contentious in many respects.

What you're trying to do is figure out what mines are going to go off in the next 30 days, 60 days, 90 days of taking over, preparing the nominee who turned out to be Tommy Thompson. He asked me to stay on, and then asked what I would like to do in the administration. I said, "Medicaid."

Berkowitz:

I see. So that finally brings you to CMS. That's June of 2001.

Smith:

So that brings me to CMS. I started in February in the Secretary's office, because at the time everybody's a senior adviser. Nobody's in place.

Berkowitz:

Had you met Governor Thompson?

Smith:

I had. When I was on the Hill back on the Finance Committee, the governors had put together two bipartisan groups to work with the Republican Congress. Tommy Thompson (Wisconsin) and John Engler (Michigan) were on the welfare side, so I got to know him a little bit doing the welfare work. And then Mike Leavitt, who was governor of Utah at the time, he was on the Medicaid reform side of things.

Berkowitz:

So the job you finally got appointed to was called Director of the Center for Medicaid and State Operations. As I understand it, you can correct me, that is the organization within CMS that runs the Medicaid Program, in terms of making sure that the states get paid and that people get care and so on and so forth. What was on tap there?

Smith:

For one thing, having a Secretary of HHS who had been a former governor and had dealt with the problems of Medicaid elevated the status of Medicaid within HCFA. You have to understand, as an organization, Medicare dominates HCFA/CMS.

Berkowitz:

Right. Going back to the Bureau of Health Insurance from the Social Security Administration.

Smith:

Exactly. So when you look at personnel, resources, et cetera, it is disproportionately on the Medicare side. Medicare was, in many respects, used to dominating, even with the Secretary. It was a big change to have a former governor, and Thompson had been elected four times, who said, "You know what, as a governor I spent so much money on Medicaid, and I'm tired of all you people at HCFA who couldn't give me an answer on what I wanted to do, wouldn't give me the waivers I wanted." So, we were there to shake things up, on the Medicaid side.

There was a tremendous backlog of state plan amendments that hadn't been dealt in the Clinton administration. I remember we had plan amendments from Missouri dating back ages that had never been acted on. So there's a huge backlog. So we've got Secretary Thompson who says, "Get rid of that backlog. Be responsive. I want decisions made. We're going to stop hanging states out to dry because of nobody being able to get the decision made."

At the same time, there was continuing controversy over the state versus the federal share of the Medicaid program. The Clinton administration, as I said, had done the managed care regulation and they had also opened up the upper payment limit controversy.

In BBA, (the Balanced Budget Act) we capped DSH, the Disproportionate Share Hospital program. When Tom Scully worked at OMB under Bush 41 and when he became CMS Administrator later he dealt with provider taxes and the creative financing. Scully said to states, "Medicaid is supposed to be a matching program. Where is your share of the match? Is it real?" This issue continued.

Those are the different priorities that we were juggling: getting financing under control and getting the backlog taken care of. But at the same time, we wanted to reform Medicaid through waivers.

Berkowitz:

Right. So let me see if I understand that. With waivers, as I understand it, the idea is to let the states experiment or let the states do their thing in some way without too much hindrance from the federal government. What were some of the innovations that attracted you?

Smith:

We came up with three model waivers, and put them into a template. The first one was the HIFA waiver -- the Health Insurance Flexibility and Accountability waiver. Only somebody from HCFA could give you something called a HIFA. We learned from that. These were waivers that -- going back to Virginia -- were in response to those questions: "Can we combine the Medicaid and the CHIP dollars to get to insure families? Can we give greater flexibility back to the state?"

One of the things in the HIFA waivers said, "We want you to do premium assistance. If a family has access to employer-sponsored health insurance, the cost of the insurance shouldn't be entirely on the taxpayer dime. Use what's available out in the private sector, leverage that."

The HIFA waiver was a template. It was an effort, not completely successful, trying to get to a simple checking the box to say this is what I want to do.

It was an 1115 waiver. Section 1115 is under Title XI of the Social Security Act. So you're actually operating under the authority of the Secretary, and then the Secretary has delegated authority down to CMS. The Secretary is approving the waiver, but we're negotiating these waivers.

This was in 2001, 2002; the Medicare Modernization Act has not been passed as yet. A couple states had come to us, to extend coverage to low-income seniors without putting them on full Medicaid. These are seniors who are at 140 percent of poverty.

Berkowitz:

Are they SSI (Supplemental Security Income) recipients?

Smith:

No, they're not. They have too much money for that.

Some states had state drug assistance programs. Some of the drug companies had gone to a couple of states and said, "We'll work with you and if you start collecting the rebates that will be the state's share. So we come out ahead because we're going to sell more drugs, and you benefit because the state's going to have a source of match."

Berkowitz:

What rebates are these?

Smith:

The law requires drug companies to give rebates to the government for drugs sold for Medicaid patients to bring the real price down to a certain level. That part is controversial; I'm not going to go there. But, we created a model waiver for prescription drugs for seniors. We got about five states that adopted our model waiver and started a drug program.

My rationale came from going back to my days in Virginia, and looking at claims data and looking at our waivers in our home- and community-based waivers for senior citizens. Going back to that, we had seen, "They're not really using many waiver services, but their drugs are out of this world. So why don't we just give them the drugs? That's what they're showing up for. That's what they need."

I argued with OMB (the Office of Management and Budget) for this. Of course Secretary Thompson was all for it. I said, "Look, in the long run, this is going to save money, because this is what states are doing. They're putting them on full Medicaid. Let's just offer the drug benefit to these low-income seniors." So, a number of states adopted that model waiver.

If you are low-income and you can't afford your blood pressure medicine, or you're splitting pills, it's costing us more money in the long run when you get sick. I saw it to some extent in California, and really saw it in Virginia. Within the Medicaid budget, it's by service: we're looking at our drug spending, we're looking at our nursing home spending, and we're looking at our et cetera spending separately.

Berkowitz:

Do we need to look at the individual receiving all these various things?

Smith:

Absolutely, yes. I go back to the statutory creation of Medicaid and a waiver. What are you waiving? You are typically waiving state-wideness, comparability, and freedom of choice. With basic Medicaid, you're entitled to what everybody else has, anywhere else in the state; that's the entitlement without a waiver. But if we start targeting, and we have someone with chronic healthcare conditions who actually needs greater services, this doesn't make sense. I keep saying, Medicaid is not a program. It is different programs serving different populations. And we need to start now looking at the different populations

which have different needs.

Berkowitz:

Which is also something primed by your developmental disability experience?

Smith:

Very much so. Very much so. I say that the low income population who is qualifying on the basis of poverty, they're there because something bad happened to them or their family -- divorce, loss of a job, something bad happened. But they had been in the workforce and we want to get them back into the workforce as quickly as possible. So we want to support them, but that support should be temporary for the non-elderly, non-disabled population.

You have the seniors I mentioned; we say of them, "Look -- if we just give them the drugs they need, then they're not going to be on full Medicaid for everything else." And if you are a senior who needs long-term care, you're very expensive, but you're really going to be there for a short period of time. But if you are there because of disability, if you were a child, you're going to be on Medicaid for 65, 70 years. We've got to stop running away from that. We've got to say, "We recognize that. So how do we help you?"

It is a family issue first. The divorce rate among families with a child with a disability is like 80 percent. So how do we keep Dennis at home? How do we keep that family together, to build supports around that family?

This gets back to the Katie Beckett story. She was a little girl born in Iowa. Her mom Julie Beckett writes her congressman, Tom Tauke, and says, "We want to take Katie home from the hospital, but I've been told that Medicaid won't help pay for her care then." The mom had been a nurse and wants to take Katie home from the hospital, where she was racking up huge medical bills.

So she writes and says, "Medicaid will pay for Katie to stay in the hospital or if we put her into an institution, but they won't pay for the services so I can take her home and take care of her." So Congressman Tauke shares the letter with Vice President Bush and it gets to President Reagan. And of course President Reagan is outraged by this.

President Reagan says, "Secretary Schweiker, you go cut the red tape. I don't want to hear about this. This is outrageous. This is not the way this should work." This was the very early days of the Reagan administration. We were thinking, "Oh my gosh, what do we do?"

So we came up with the idea of waiving the rules. And then we said, "Well there's got to be more than one Katie Beckett out there." So, eventually, that's how home -- and community-based waivers get created. There were a lot of people who said, "If you open this up, there will be such demand for this, you won't be able to sustain it." But this was done at a very personal, compassionate level. So, since the early 80's, I've been trying, bit by bit, to say states shouldn't have to come to Washington for a waiver to do the right thing.

Berkowitz:

Of course, there are still standards of care issues that are involved there, when you first get the person home?

Smith:

The standards of care -- well, we like to think we've invented quality. You don't invent quality. Quality comes from that home health aide who is taking care of Dennis or Grandma Smith with dignity and compassion. That's what it is. We can write the best quality manual on the planet, and bring in all the academics, and bring in the clinicians, and work groups and everything else. But if you don't have access, what good does that do you? Because you have now priced quality out of anybody's control.

I'll digress even further back to the time when I'm looking for a job in little Walnut, Illinois --

Berkowitz:

This is back to when in time?

Smith:

This is in the mid '70s. My older sister, Elaine, has graduated from college. She is still living at home, and she gets a job at our local nursing home, Walnut Manor. She had been there I don't know how many months. She told me, "I'm looking for summer work and the nursing home paid 25 cents an hour more than the grocery store." So I go and work as an aide -- first male to work in the nursing home. The administrator was male, but other than that, everyone was female. I fell in love with the people that we were taking care of. I have no formal training or anything. But the guys like talking to another guy. We talked sports or how the crops look, that sort of thing.

And at the time, the nursing home is clean, family members are coming in, and I'm thinking at the time, "This is a great thing." Looking back at it now, I think "You've got to be kidding." I was waking a 75, 80-year-old man up at 7:00 in the morning saying, "It's time to get up. No, you don't get a shower today. Today is Monday. You get your showers on Tuesdays and Thursdays." At nursing homes at the time, the residents were working around our schedule.

Berkowitz:

So it's another institution that doesn't serve people very well as individuals?

Smith:

Precisely. We have it backwards. Again, you won't find the Wisdom of Solomon in the Federal Register. The dignity of the individual has to come first. And I am afraid, and I greatly fear that the federal government is spending a trillion dollars on healthcare. Is the dignity of the individual really the center of how we spend all of that trillion dollars? I have my doubts.

We keep coming up with proxies. Managed care was going to save the day. Managed care hasn't saved the day. Now we're experimenting with ACO's (Accountable Care Organizations); we're going to pay on quality, not on volume. Are we just getting off one hamster wheel onto another? It kind of looks that way to me.

Berkowitz:

One thing that seemed to have come up in that period of time when you were the Director of the Center for Medicaid and State Operations was a dispute between the administration and Congress over SCHIP funding. The administration wanted to hold the line on expenditures, and the Congress saying, "No, no, no. This is very important. We have to increase the expenditures." Were you involved in that?

Smith:

Yes. I was involved in the re-authorization. MMA got passed in 2003; the Deficit Reduction Act of 2005 got passed; and then we go to SCHIP re-authorization.

Some of the CHIP allotments were funded over time; a state has three years to spend the allotment, et cetera. Some of these states start running out of their allotments. They had expanded higher and higher up the income scale. At first, we quietly said, "Okay." There were a handful of states like Rhode Island that also had put parents on, and were getting some of that support.

I said, "Look. The whole idea was the state was going to have the flexibility to go higher on the income scale. But you could do that only if you could finance the program. And now you're overspending the allotments and coming back to Congress, saying, 'You've got to fill us up again.' "

It came to a head when New York wanted to expand to 400 percent of the federal poverty level. That's not who CHIP was for. You have a serious discussion about who should be on these programs. CHIP was never intended for all kids. It was intended for a very specific group of kids – those in families that earned too much to qualify for Medicaid but not enough to be able to afford insurance on their own. When you basically say, "There is no limit," then you have changed the purpose of the program that you have created.

I'm having this discussion with myself; I'm having this discussion with other people. During this period of time Mike Leavitt has become Secretary of HHS and sees as a huge priority that the Bush administration needs to come up with a state-based approach to help increase access to health insurance.

Berkowitz:

Wouldn't that expansion of SCHIP do that?

Smith:

Well, SCHIP had already expanded to kids at higher income levels; also we negotiated the Massachusetts waiver -- reallocating funds out of a funny money scheme that had started in the Clinton administration. And so, Governor Romney comes up with his vision, which fits very much into what Secretary Leavitt wanted to do as well. But, then comes the New York situation; the way the New York language actually read, there was no upper income limit. Virtually every child in New York would be eligible for the CHIP program.

Berkowitz:

Did they have local matching also in New York?

Smith:

Yes.

Berkowitz:

So that's a constraint.

Smith:

Well, they also had a number of financing deals. Their provider tax was deemed to have been approved. HCFA never looked at New York's provider tax scheme, which is actually part of the CHIP deal with Sen. (Alfonse) D'Amato. So a child in a family with no limit on the income would be eligible for this public assistance program. But you've got a 55-year-old carpenter who falls off a ladder, gets hurt, and can't go back to work. We're going to say, "We have nothing for you." Just didn't make sense to me.

Berkowitz:

We have worker's comp for him?

Smith:

Well, if he's self-employed, it's a problem. People are not uninsured, they are self-insured, and they can't afford to be. So, get in the pool. That's what insurance is all about. It's being in the pool. But this sort of inequity always troubled me. Eligibility at any income level for a child, but if you're at 50 percent of poverty, there's nothing for you because you're a childless adult.

Berkowitz:

So it's the hazards of the categorical nature of Medicaid and similar programs?

Smith:

Right. And that makes no sense.

Berkowitz:

Getting back to the time that you were Acting Administrator of CMS at the end of 2003, the beginning of 2004 -- is that a fairly critical time?

Smith:

It was. The MMA had been passed in December. Tom Scully was there, this is what he was there for -- to get the drug benefit passed. That is successful, and he leaves.

Berkowitz:

It's the ending of a term.

Smith:

Correct. There wasn't a whole lot of discussion about it. Secretary Thompson asked me to be the Acting Administrator, and said, "We've got to get going. The drug benefit starts right away. We've got the discount card. We've got a whole lot of things that need to be done."

Berkowitz:

Were you still also the Director of the Center for State Operations?

Smith:

Yes.

Berkowitz:

So you did two jobs?

Smith:

Yes. We really were starting on the work plan, on how was all of this going to work with seniors picking a health plan. It hadn't really happened before, and now we were going to do it on a large scale.

Berkowitz:

There had been the implementation of Medicare Part C. Was that something similar?

Smith:

To some extent, but with Part C, you didn't have to pick it. You could still just do traditional Medicare A & B. If you wanted your drug benefit in traditional Medicare, you had to pick something, a health plan, in D. And we hadn't really done that before.

We asked ourselves, "Okay, what do we have going for us?" We have the Social Security Administration, the most trusted name a senior has. Everyone knows Social Security, loves Social Security. We're going to have to start coordinating with them. They're going to be a part of this. Medicare really didn't have an eligibility test in terms of income. But for Medicare Part D there is a question of who was going to qualify for what subsidy level. On the Medicaid side, we knew how to do that. The Medicare folks had not a clue how to do that. So we really started forming new teams of bringing together people who could explain income eligibility to the Medicare folks.

This was a great benefit to the seniors of the country, obviously. But it was a great challenge to us as an institution. And the response was tremendous. Everybody wanted to work on it because it was a new project; it was a new way of thinking. There was a lot of energy; there was a lot of excitement in the agency itself.

Berkowitz:

Let me ask you just one last question, if I might. If someone made you the czar and said, "Tell us about the future of Medicare and Medicaid," what would you respond?

Smith:

In many respects, it concerns me that CMS has been given too many responsibilities. Medicaid has been given too many responsibilities. Medicaid is funding things, things that I approved, things that I encouraged states to do. But Medicaid cannot be a housing program. That's somebody else's job. The money that we're putting into schools -- yes, we need teachers' aides in our schools, but it's not Medicaid's job to fund that.

We have to do some serious fundamental rethinking of who these programs are for. Who

should they serve? How should they be served? CMS controls \$1 trillion, half of our personal healthcare expenditures. I think in many respects it is too big, too complex. And when you do that, then you're doing lots of things, but you're not doing any of them really, really well. If Medicare is going to fundamentally change on the financing side, that's the only thing they should do.

The Administrator of CMS has all of these things he has to juggle. This is more than really hard, no matter who you are and I've met an awful lot of smart people. There was Bobby Jindal at HHS, one of the smartest people on the planet, and Mark McClellan -- a doctor and a Ph.D. in economics. Nobody is smart enough to run the amount of spending that's under CMS.

We ought to be looking at the future. Look at what's going on in California with the public hospitals. California added something like 2.5 million people. And what are you hearing out of California? The lack of access.

There are fundamental things we that have ignored for years. You look at New York and the hospitals, the over-bedding. All of the money that we are spending to keep hospital beds that have a \$100,000 debt attached to it. An awful lot of spending that gets called Medicare or Medicaid is really something else entirely, and we've got to have that discussion.

We can't keep propping up hospitals that are at 40 percent capacity. We need to have a discussion about 20 years from now; what do you need a hospital for? Twenty-five years ago, if you needed oxygen, where were you? You were in a hospital bed. And now on Sunday morning there are little old guys out on the golf course pulling their oxygen tank along with them. There is too much talk about today's crisis, today's here-and-now, and not enough at all about the future.

Berkowitz:

That's a great place to conclude. Thank you very much for your time.

Smith:

You are welcome.

Interview with Marilyn Tavenner

By phone on April 27, 2015

Interview conducted by Edward Berkowitz

Transcript edited for clarity

Berkowitz:

Today is April 27 and I am talking with Marilyn Tavenner. This is a continuation of an earlier project in which most of the administrators of CMS have been interviewed to create an oral history archive.

Starting with your personal biography, I see that you were born in deep southern Virginia in an area known for tobacco and textiles. And, if I read correctly, nylon was invented or made there?

Tavenner:

Yes, I grew up in a little town called Fieldale, which is almost on the North Carolina border, but it's in Henry County. Both of my parents were entry-level textile workers. I'm the oldest of four children. Certainly some of my family worked in tobacco, but most of them worked in textiles. My parents worked for Fieldcrest at one time. I certainly had relatives, many of which are still there, that worked for DuPont, which is where the nylon piece came from.

Subsequently I moved to Roanoke. I went to nursing school on a combination of a hospital and state scholarship. My father died when I was a senior in high school, so I had some veterans' benefits and Social Security benefits, and put all that together and went to a three-year diploma school of nursing. When I finished there, I moved to Charlottesville, and then ultimately to Richmond. I wanted to work in critical care and in heart surgery and that wasn't too common in Fieldale, so I worked my way to Richmond, and I've lived all my adult life in Richmond, Virginia.

Berkowitz:

I read the testimony at your confirmation hearing. In that statement you mention your mother in particular as an important influence in your life. I got the impression she kept working through much of your childhood. Is that right?

Tavenner:

Yes. My father died when I was 17. My sister was 15, and I had twin brothers who at that time were kids. So she worked all of her life and basically took care of the four of us. She died last May. It's almost been a year, but she was 89 when she died. She was a big influence on me because she was always a working parent and supported whatever I wanted to do. She was a very strong role model to me for that period of time.

Berkowitz:

You said that after beginning your nursing career you spent most of the rest of your life in Richmond. Was that a choice -- "I want to live in Richmond" -- or did that just happen in the course of your life?

Tavener:

It came up in the course of things. I got married along the way and my husband is from that area.

We actually lived in South Hill for a while. He was with the state police at the time. We moved back to Richmond because we both ended up putting each other through school, through undergrad and graduate school, while we were working and raising a family. We went to Virginia Commonwealth University and then, ultimately, he went to the University of Richmond to law school, and I did graduate school at VCU. Living in Richmond was a matter of his family being from that area, and it was the place where we could both go back to school to finish our education. We were both in our 30s when we finished grad school.

Berkowitz:

You went to work at some point for the Hospital Corporation of America, HCA. If I read the record correctly, you started out as a clinician there, as a nurse in one of the hospitals they owned. Is that correct?

Tavener:

Yes. When I first went to work there it was 1981. That's when we were moving back to Richmond to start school. And so I took a job, nightshift, as the 11:00 p.m. to 7:00 a.m. nursing supervisor. I was doing clinical nursing there until I became director of nursing. And even then the director of nursing has a little bit of clinical, but not very much. It was about 1987 when I became director of nursing, and then, ultimately, became the CEO at that hospital in '93. So I started out there on the nightshift working as a nursing supervisor and kind of worked my way up. I was assistant director of nursing; I did quality management for a while; and then, ultimately, I became the director of nursing, and then the CEO.

Berkowitz:

That couldn't have been a very usual -- it's a quite a meteoric rise.

Tavener:

[laughs] It was -- it was a very unusual path. I had really good working relationships with the medical staff and the board there. And they championed my becoming the CEO. So they had a lot to do with my position, for which I am eternally grateful.

Berkowitz:

You had education in healthcare administration at some point; right?

Tavener:

Yes. That was in the '80s. I had finished my master's in health administration in 1989; that's when I was director of nursing. I was working and then going to school part time. It took me six years to finish my graduate degree because I was taking it just six credits at a time.

I then became the CEO in '93 and stayed there in various roles in Richmond running the Richmond market. We merged two hospitals together and, by 2001, I became the president of what was then the Central Atlantic Division, Hospital Corporation of America. Ultimately I ended up in Nashville for a couple of years running the out-patient group. It was at that time that Tim Kaine became Governor of Virginia and asked me if I would come back and work with him as Secretary of Health.

Berkowitz:

Was the Health Corporation of America a comfortable corporate climate for women to advance in?

Tavener:

That is a probably still a great question today. I can't say that there were a lot of women in senior levels at the time I was there. There was a person who was working in the financial area and a person who was working in information technology, but most of the corporate climate was male; so I think my rise was a bit unusual.

Then, at one point, when I was in Nashville -- this was around 2004 or 2005 -- Jack Bovender was the CEO and he made a conscious effort to attract women and minorities because the history of HCA had been predominantly white male. Changing that was something very important to him. He was recently honored in *Modern Healthcare*, and they talked about that program which was something he was very proud of. And so I think the company has made, like many other companies, a conscious effort over the last couple of decades to attract women, attract minorities, but it's hard.

Berkowitz:

Getting back to your work in the government of Virginia -- as I understand it, you met Senator Kaine when he was the Mayor of Richmond. Was that meeting from your business circles?

Tavener:

It was from my business circles. I was pretty involved in the community and, obviously, as Mayor he was as well. We were working on "Success By 6," a pre-K development program. We were also working on some healthcare issues. At that time, Chippenham Hospital was in the city and Retreat Hospital was in the city, and they were both areas of responsibility for me. So we were trying to create better healthcare in the city and better pre-K in the city.

We started seeing each other at different meetings and getting to know each other. I held Tim Kaine, and still hold him, in very high regard. He's really, really a strong, ethical, great guy. When he ran for lieutenant governor, I helped in his campaign, but then I moved to Nashville, although I still stayed in touch with him. We would meet once or twice a year.

I supported his run for governor and thought he would be a great governor. Once he was elected, he contacted me and asked me if I would be interested in coming back and serving as Secretary of Health. To me, that was a great opportunity. I had been interested in policies for a while, particularly in the issue of the uninsured, and wanted the chance to

see if I could make a difference, do something on the public policy side; so I made the decision to leave HCA and come back to Richmond.

Berkowitz:

You worked in that cabinet-level post in the Commonwealth of Virginia between 2006 and 2010, which is actually a long time for someone to be in a position like that. Did you think of yourself as in it for the duration of the term?

Tavener:

I did, yes. The Governor of Virginia is a one-term governor, four-year term. So I went in with the idea that I would stay through at least most of that four-year term. Once I got in, I really enjoyed working with the Governor, so that was an easy four-year decision. There was a lot to do and during that time we went through the tragedy at Virginia Tech so there was work going on in mental health. We were trying to expand Medicaid. We tried and failed at a couple of runs at finding some creative way to address the issue of the uninsured. We couldn't get those out of the House; still the problem in Virginia, sadly. So the four years went by quickly. And it's at the end of the four-years and I'm trying to decide what to do next. That was the summer of 2009 when there was a great deal of debate going on about the Affordable Care Act.

The ACA for me is back to the access issue again. I love many pieces of the Affordable Care Act, but the piece that probably was the most appealing to me was dealing with the issue of the uninsured. I had seen up close and personal how many people, who were hard-working individuals, either couldn't afford insurance or had preexisting conditions, or had some reason they couldn't get insurance; I dealt with them on the hospital side. HCA was extremely generous and, as the CEO, I could discount prices. I can't tell you how many people I put on these \$5 a month payment plans -- they're probably still paying them today -- to try to help. I felt like we needed something from a policy perspective, not just me discounting those individuals who made it through the administrator's office.

Berkowitz:

If you look at administrators of CMS or HCFA, there are different models. One is more a nonpartisan administrator-type, trying to make the trains run on time. The other is more of a partisan figure. It sounds to me like you're now identified as a Democrat; is that correct?

Tavener:

[laughs] I think that's correct. Although I will tell you that many Democrats and some of my Republican friends say that maybe I'm still Republican. I kind of identify myself as a Democrat, for sure. I like the fiscal responsibility and discipline that's sometimes a little stronger in the Republican Party, but the social issues drive me to the Democratic Party.

Berkowitz:

I see. When you were at the Hospital Corporation of America, did you also self-identify as Democrat?

Tavener:

No, not so much. We supported both parties, and there wasn't really a lot of push for people to give at a personal level. That was kind of up to the individual. But probably for the last several years it was more about the individual candidate. I liked Warner; he was a Democrat. I supported him for the governor, and I supported Kaine. But I also like Eric Cantor and I supported him, and other Republicans. So I donated to both parties.

Berkowitz:

Some of the people who have been the administrator of CMS know a bit about Medicaid, but the more usual thing is that they know more about Medicare. But in your case, it's not true, is it? Coming from the state background, you would have known more about Medicaid, it seems to me.

Tavener:

Yes. I actually had the advantage of knowing about both programs. I'd worked with Medicare from my hospital days more than Medicaid. Then I had the Medicaid experience in state government. So it was actually the best of both worlds.

Berkowitz:

Let's now talk then about your coming to federal government and to CMS -- which I think happened in 2010. Had you known Don Berwick before?

Tavener:

I didn't know Don personally. I certainly knew him by strong reputation, a great reputation. When I first went to CMS in February of 2010, it was to be the person to keep the trains running on time. I was to be the principal deputy. That was my background, and I was very interested in that. Don had not yet arrived. But, at the time, I knew there was going to be a physician to be the administrator, and I thought it was Don. And then after I had started, Don came on in July. So got to know Don during the time he was there; he was there for about 18 months, and we worked together during that time. But I had not known Don personally before I started at CMS.

Berkowitz:

So how did you get this appointment at CMS? Was it a presidential appointment?

Tavener:

It was a political appointment. I went to interview with Bill Corr, who was the Deputy Secretary. I started my interview there, but I feel certain that Senator Kaine-- now Senator Kaine, but then Governor Kaine -- and Senator Warner certainly helped support my moving forward, my nomination. They were interested in finding someone who had operational background, and I fit the bill. I'd like to think some talent with some political luck, if you will. But I came in with the idea of being the principal deputy, that I would be the number two person.

So Don and I set out working together. I would do more of the, what I'll call, the day ops, and he was more into -- obviously, his background would be on the patient side and the quality side and that sort of thing.

Berkowitz:

Computers and computer systems probably came up throughout your career, but notably during your career at CMS. Are data management or website creation things that you considered among your specialties, or are they just something that is part of the portfolio of being a manager in healthcare?

Tavener:

Well, sir, I wouldn't say that website creation was my specialty because IT, information technology, is not my background.

My background is clinical. I certainly learned a lot about IT during my time at CMS. We were able to take a system that had a rocky start and get it into a highly functioning system. But, obviously, I was relying on contractors with IT expertise. I didn't come to CMS for IT management; it was more for general operations. There's a lot more to CMS than IT, obviously.

From the time that we started working on the www.healthcare.gov website, probably the first part of my time was spent on rules and regulations. The second half was spent on perfecting it, and certainly a website, but it was so much more. The website was a piece of it, and obviously it's an important piece. But probably much more time was spent on the insurance side, the changes as relate to insurance. The whole idea of having different management plans and portfolios inside each state and each market, it was a phenomenal experience.

Berkowitz:

As you know, CMS was originally created by President Carter; he wanted to bring Medicare and Medicaid together in one agency, and make health a priority. It is interesting that these healthcare exchanges in the Affordable Care Act are also run by CMS. Was that something that was just understood by everybody?

Tavener:

Well, originally, running the exchanges was independent of CMS. Originally, there was a small group reporting directly to the Secretary. It was a small agency, if you will, that reported to the Secretary. And then -- I think it was in 2011-- because there were so many common functions that existed inside CMS, the decision was made to move the marketplace, the exchanges, inside CMS and not have to duplicate everything. The goal was to be able to have some efficiency, to not have to reinvent the wheel.

Berkowitz:

What was the reaction of the folks that were the CMS employees to that new task?

Tavener:

I think the CMS employees were thrilled. It was a huge learning task, but they were in the midst of huge learning around the Affordable Care Act anyway.

I'm not saying everybody loved it, but most of the employees at CMS fully embraced the idea of participating in the new work, to be part of that was exciting. Now, the workload was phenomenal, and we had to bring in some additional resources and those sorts of things.

We spent 2011 and 2012 kind of blending the systems for CMS and the ACA's functions together and learning from each other. Even when the ACA was separate, there were a fair amount of CMS staff that had gone over to the original small agency reporting to the Secretary. And so to a certain extent they knew CMS and they were comfortable with CMS, so that made it a little easier in some ways.

Berkowitz:

Clearly, in your time at CMS the coming and implementation of the Affordable Care Act is a major thing.

I was wondering how you prioritize something in an agency that's got so many different tasks like CMS does. How do you establish priorities in that setting?

Tavener:

Well, that's also a great question. A lot of the priorities were driven by the fact we were on a timetable with everything from Medicaid expansion to payment changes to developing the new innovation center. The priorities were kind of mapped out in the Affordable Care Act and there were definite timelines. So, of course, you're trying to meet those. Then you're trying to also think about the long term.

For instance, one of the things that we wanted to do is have a single quality program. If you're a physician or a healthcare provider, your patient one day can be Medicaid, one day can be in the private market, and then, ultimately, may end up in Medicare. We didn't want to have programs that were so different. So we spent a lot of time -- that's when we hired Patrick Conway, he's been a great addition -- and set out to have common quality measures wherever possible. It's actually possible in most circumstances. Obviously, some of the populations are a bit different. You're dealing with newborns more with Medicaid and in the private marketplace than certainly you are in Medicare.

So that was a priority: establish the same kind of quality matrix across the system. Another one was to establish the same sort of measurement tools for everything from hospital-acquired conditions to readmission. So, regardless of the payer or the person, they would be treated the same; they would know what to expect; the physician would know how to manage them.

Those are the kinds of priorities that were overlaid across what would've been the day-to-day implementation. We had to have the first exchanges done by x-date in '13. We had to have Medicaid expansion available by January 1 of 2014. So there were certain time measures that were priorities of law. And I think that's always been true for CMS to a certain extent.

Berkowitz:

When you were confirmed as CMS Administrator, one of the things you said, I believe, is that we should think about CMS sort of like a business. It has to be run efficiently like a business. What are the particular skills that go into that? Is there such a thing as an ideal CMS Administrator?

Tavener:

I've often had that conversation with people. I think the CMS Administrator, certainly in today's environment, maybe it's been true historically as well -- it helps if you've had some operations management.

But a third of your work is about the political environment. You've got to get along with Congress. You've got to get along with the White House. You've got to get along with the Secretary. A third of you is policy where you're trying to take Congressional intent, turn it into policy or trying to create policy within your scope.

Then the last part is operations. You have to be able to run a staff of about 6,000 people, manage contractors, manage IT projects. So there's a big part that's also operations. And I think you see that more in CMS than you do in some of other agencies. It's a little different than running HRSA, the Health Resources Services Administration. HRSA is a very important agency and is key to making sure that we have adequate supplies of medical practitioners, nursing and other practitioners, but you're not running -- you're not paying bills, you're not measuring quality. It's a little different, if that makes sense. So I do think the business background is helpful.

Berkowitz:

Right. You were named the acting head of CMS in December of 2011, I believe. And you were finally confirmed in the spring, May 15th, 2013. Could you comment on that experience -- being named the acting head, then being named the head? Are the jobs of acting head and actual head different from one another?

Tavener:

I don't think the day-to-day management and work is different. What I think is different once you're confirmed is that it creates, I think, a tighter working relationship with Congress -- and that can be anything from hearings to work on policies. I just think you don't have as much Congressional interaction when you're acting as when you're confirmed. But the day-to-day work is pretty much the same. I'd been acting administrator in 2010 before Don got there, then I went back to my regular job, as they say. And then from December '11 until '13, I was the Administrator, running the agency. From that practical experience, I think the two jobs on a day-to-day basis are very similar.

Berkowitz:

I see. You said that if you're named as Administrator your interactions with Congress might be fuller or more extensive. I'm curious about that. Why would that be true? Is that because the administration sends you up on the Hill more if you're the actual Administrator and you're considered more of a spokesperson?

Tavener:

I think it's the other way around. I think Congress asks for you more when you are actually the CMS Administrator. They see you as somebody they confirmed, so they see you as working for them or with them as well. And they don't see that quite as much in the acting world.

Berkowitz:

I see. In terms of these various appointments, when you got to be acting head and finally the Administrator, who were you dealing with? Did you have a lot of contacts with particular people in the White House that were making these decisions? How did that all work?

Tavener:

When my name was put forward, obviously that's put forward by the President. But at a day-to-day level I was working with the Secretary, with Secretary Sebelius. And so that was a lot of the contact work. And then you go through the Senate; the Chairman of Senate Finance at that time was Max Baucus.

So you're working with the Senate Finance Committee and the Chairman of Senate Finance. I was working with Senator Baucus or Chairman Baucus and his team. I certainly worked with our legislative office inside CMS, and inside HHS, and then there's a legislative office inside the White House. So then it includes going to visit Committee members, talking to them about your vision for the agency. And then, ultimately, you go through a set of extensive paperwork, both financial and nonfinancial, that has to go through a review by committees in Congress.

Berkowitz:

Right. I was struck in reading the transcripts of these various hearings regarding your confirmation by how much the Senator would bring up something from his home state and say, "Well, in Oregon I've been visiting with people, and I've seen this." I guess you just learn that's the style, right?

Tavener:

It is. And I think that's true with many members of Congress. I had a very, very strong bipartisan working relationship. I think the reason for that is I was there for a long time. I was there for five years, and most Administrators, acting or otherwise, aren't there for a five-year period. And during that time, during the five years, I would work with individual members of the House and members of the Senate about something that was going on in their state or their district. So I got to know them a little and got to know their teams a little. So I don't think it's unusual for members of Congress to ask about something going on in their state.

Berkowitz:

Right. Robert Ball, who was the head of Social Security for many years, said once that going to a Congressional testimony was like going to a final exam. He would stuff a big briefcase full of stuff. And Wilbur Cohen, who was another old hand in the founding of Medicare, said that he was always deliberately vague about things when he testified because he wanted all ideas to come from the Senator or the Congressman. He wanted the Senator to suggest something and then he would say, "Oh, that's a good idea, Senator." Did you have experiences like that that?

Tavener:

[laughs] I'm probably more of the first school than the second. When I went to testify before Congress, I basically studied everything, not only what I had in my portfolio, but

some of the history of the Agency, decisions that had been made, in case Congress brought up a question. So, yes, it's definitely like studying for a very important final exam.

Berkowitz:

I see. Was the day before the testimony sort of like the presidential candidate preparing for a debate? Was there a lot of briefing going on?

Tavener:

[laughs] Yes. Usually the week before; by the day of the testimony I was like okay, enough. I've packed everything I can pack in my head. The day of the testimony was to decompress and get ready. I wanted members of the House to bring up their ideas for sure, and if they were good ideas always tried to follow up on them. I definitely prepared for those hearings.

Berkowitz:

I see. One of the things that have come up in your era of health care policy is this idea that we can't just reimburse providers on a traditional fee-for-service model. There is now the idea that somehow we have to figure out a way to pay for quality or better performance or something like that. Was that an interest of yours?

Tavener:

Oh, absolutely. I spent a great deal of time on that. Much of the work that we got done on that during that period is something that I'm most proud of. I would say probably the biggest thing is to have decreased the number of uninsured. The work we did on the uninsured and the work we did around quality and tying quality to payment are the two things I'm proudest of in the last five years.

On quality, in addition to working our way through hospitals and nursing homes and some of the criteria that were in the Affordable Care Act, we were also able to get into the Part B section of Medicare. We were able to tie physician payments to quality, hospice to quality, home health to quality. I think most people agree that just paying for volume, repetitive volume, is probably not in the best interest of the individual, the consumer, or cost.

The question is, how do you connect these two—payment and quality-- together so that you've got a better outcome? I think years ago we started connecting quality to better process, and now we're actually trying to connect quality to better outcome.

I hope that the work I do in the next several years is still tied to that in some way.

Berkowitz:

I see. It's a tough thing to explain to people. It's one thing to say we want to have better quality care but the actual logistics of it, like a lot of things in Medicare, is really quite complicated. How do you communicate that idea to a member of Congress or someone else?

Tavener:

Yes. I think this is something that is bipartisan. I think if you talk to either side of the aisle they're interested in this idea. People grapple with how do you get it done, but I think most people understand it's the right direction, it's the direction you want to go in.

I found the best way to explain it was usually to use an example with a Medicare patient who was also on Medicaid, or what we call a "dual eligible." We would talk about duplication of services, or fragmentation of services -- how many times did the family end up becoming the person who had to navigate the maze to make sure that someone, particularly someone with more than a single illness, got what he or she needed?

Most of us do fine until we get sick. It's when we get sick, particularly if there's more than one illness, that you start to see the duplication or fragmentation of going from place to place to get care, or going one place and having the same tests repeated. I think that was the way I usually tried to explain it. I think people understood that from their personal experience or from their parents' experience; they usually had an example they could refer to.

Berkowitz:

So let's talk a little bit the rollout of the Affordable Care insurance plan. There was a time in the fall of 2013 that you were in the news more than is usual for someone at CMS. You made a public statement at the end of October about we should have done better, or something like that. You were involved, it seems to me, in some very heavy political situations there. How did you keep your sanity through that?

Tavener:

[laughs] So -- great question. I have always been the type of manager that -- I don't believe in a very big hierarchy, and that was true even in Medicare. So although I wasn't the IT expert, I knew the individual that had been working on the project. I knew some of the contractors. I think it was a classic example of everybody had part of it right, but the pieces weren't connecting in a way that they should.

And so the way I kept my sanity is I talked to the team; my first concern, obviously, was getting the project to work, but also my concern was keeping the morale of the team up in that kind of environment, particularly when it's on the front page of *The Washington Post* and everywhere else every day. So we pulled the team together, and I said, "Guys, we know this works in part, it's just not working smoothly." Because we had, even on October 1, with all the volume issues and the issues on the front end about signing people up, or going through the security piece, we had some individuals that got through. So I said "We know the system can work. We need to pull in the IT team. We need to all pull together so we can either put our head down and get this to work, or we can just read the paper or watch TV." And I would say "Let's ignore the paper, let's ignore TV. The way that we're going to calm this down is to get the number of enrollees up, and that's what we're here for." I'd point out as we are able to enroll people, this rhetoric will go down. And that's exactly what we did.

We spent many hours, as you might imagine, in October and November, going back over, dissecting, and making the changes in the system to make it flow. We didn't change what we had, but what we had was not connecting. It was not firing on all cylinders. That's the

way I would describe it. And so we had to figure out how to make that work. We obviously brought in a lot of IT help with Todd Park and folks like that. You know; you've read all the stories. That certainly helped. The CMS team helped. The contractors worked night and day as well. So it was a matter of leadership and everybody pulling in the same direction to get it done.

Berkowitz:

I see. I was just thinking as you were saying that people of a certain age maybe remember calling the post office or the train station and either getting a busy signal or just having the phone ring. People's expectations about that kind of thing really have changed, haven't they? Yes, they expect to get through. They expect it to go quick.

Tavener:

[laughs] Yes. The world today is a 24/7. I was thinking that doing this kind of implementation job, it would have been good to be working for Franklin Roosevelt, in that time.

Berkowitz:

Exactly. Even the founding of Medicare was done pretty much without computers.

Tavener:

There you go [laughs].

Berkowitz:

They were guessing about everything.

Let me ask one or two more questions, if I might. You had a very long run at CMS compared to other folks who have been in that position. Were there any parts of CMS that you thought were run particularly well such that you say, "Oh, I don't have to worry about that. That's being handled by X-division and they're the tops?"

Tavener:

I would say probably the division that's one of the strongest was the quality division. We had strong quality leaders. We were going through those years that PQRS (Physician Quality Reporting System) and all these different systems all came on board -- somewhere between 2004 and 2014. Well, a lot changed in that. So we had strong people who could figure out how to put it together. So I didn't worry so much about how to keep it all on track. We need to make sure we hit our timelines. But the people had great talent. They were a group of people I could depend on; they were going to get complicated regs out on time; they were going to get the work done.

Medicaid was a different story, meaning Medicaid had not been front and center in the CMS world. And all of the sudden it's front and center. And then after the Supreme Court, it's front and center and it's complicated. Cindy Mann was great bringing in talent to hire and step up. Medicaid needed a lot of work which Cindy was able to do and we got a talented team in.

And then, obviously, with the ACA Marketplace, we were starting with nothing. And with the Innovation Center you're starting with nothing. So it was a combination of not only recruitment, but creating a business plan, and finding a team that knew how to implement and think in order to run a business plan.

So I definitely say we spent much more time on Medicaid and Marketplace. And, fortunately, I had good strength in Medicare and in the quality world, and even in survey and certification. The problem with survey, in short, is sometimes we get so into our routine so we don't update the routine like we should. But there's talent there. So they kind of tow the weight, if you will, and actually loan their expertise to Medicaid and the Marketplace. Fraud and Abuse was pretty strong, but Fraud and Abuse is going through a big change, so we were also trying to take Fraud and Abuse from the old, what I call, the cop-and-robber mentality to an IT platform of predictive modeling. There's a lot going on at CMS right now.

Berkowitz:

So now I have two more questions for you. The first one is why were you the only head of CMS that was confirmed for something like seven-and-a-half years in both Republican and Democratic administrations? What's your take on that?

Tavener:

I've listened to the story from people who were there during the whole time. And for CMS staff, it was a big deal to have a confirmed administrator because they felt like that was somebody that was going to be there and they knew whom to follow.

I don't know that I have the magic answer for that. In the last years of the Bush Administration, they put Kerry Weems up, but for whatever reason -- I think then maybe it was the Democrats not wanting to confirm -- he wasn't confirmed. And then Don came along and, for whatever reason, probably because of the Affordable Care Act, he was blocked. And I just think in my case, I think it had to do with having relationships with both sides, and I certainly have supported both parties. And maybe there was some concern that you're in the midst of all this change and at some point neither party looks good that they haven't confirmed a CMS Administrator for such a long period of time. I don't have the magic answer there.

Berkowitz:

My last question for you is this. You've looked at the healthcare system from a very privileged position. Has that made you see more clearly now as a civilian what should happen to Medicare and Medicaid in the future?

Tavener:

Yes, I think it has. I would say, particularly in Medicaid, you won't be surprised to hear me say that I think the Medicaid expansion is critical. And I feel that's pretty clear. Do I think Medicaid is perfect? No. Medicaid needs a lot of work. But I think the whole idea about having a consistent level of coverage is critical because what we're seeing in states that haven't expanded Medicaid coverage is that they are actually going to have lower overall health scores. The lower health scores are not because of problems with Medicaid, but because the uncovered people don't have access to the care they need.

And that's not good. So I think I have a clear vision about what's needed in Medicaid. Now, I also think Medicaid can be improved, can be simplified even more. I think that there are economies that we've learned and these need to be widely implemented. There are some things that Medicare has been doing that Medicaid can adapt.

Berkowitz:

That is the end of our time and a good place to end. Thank you so much for doing this. We really do appreciate you taking the time.

Tavener:

It was fun and I appreciate your interest. If you need to call me back or email me or anything, feel free.

Berkowitz:

Thank you.

Interview with William Toby

By telephone on June 26, 2015

Interview conducted by Edward Berkowitz

Transcript edited for clarity.

Berkowitz:

Today is June 26th, and I'm talking by telephone with William Toby. He is in, I believe, Long Island -- is that where you are?

Toby:

Yes, Rockville Centre.

Berkowitz:

And I'm here at home in Baltimore, talking by telephone. I want to ask you a bit about your life and your government work, in particular your work with the Health Care Financing Administration. I think you were born in the South about 1935. Is that the right year?

Toby:

Right. I was born in Georgia.

Berkowitz:

Ultimately you moved north to New York City. I wonder if you could just talk about that background a bit because it's unusual among HCFA administrators.

Toby:

[Laughs] Yes. Well, I was born in Georgia and raised in Savannah and New York City from age 12 when I came to New York City in 1948 to live with my maternal uncle, Mose Small. At 16, I dropped out of high school because my uncle and his wife separated and lied about my age and joined the Air Force during the heat of the Korean War in 1951. I served 3 years in England and was discharged at 20.

Berkowitz:

Can I ask you, why the Air Force? Why did that appeal to you?

Toby:

I was working in the New York City garment district pushing one of those carts with those beautiful winter coats in the rain and cold.

Berkowitz:

Like you see on the street there in the garment district?

Toby:

Exactly. And so, one evening after work I was on the subway where I saw an advertising sign that read "The Air Force needs you." The next day I went down to Whitehall Street

and lied about my age -- said I was 17. I took the exam and apparently made a very high score because they wanted me. My guardian uncle signed for me falsely certifying that I was 17. Anyway, I am not proud of having lied about my age but had a romantic notion of serving my country and at the same time get three meals a day because I was truly poor.

Shortly after joining the Air Force, my squadron was shipped out, during an emergency, to England to protect it from the possibility of a surprise attack by Russia which might attack Europe while our country was involved in the Korean Conflict. I understand the White House made that decision based on CIA intelligence. So, I spent 3 years and a half in London, Bushy Park, which was near Hampton Court, and Newbury air force bases.

While in England, I attended high school GED classes at night which were run by the University of Maryland under contract with the Air Force. I was lucky to pass the New York State GED test and was granted a high school diploma. Incidentally, as a G.I. one could also get a four-year college degree in that program. But I was a high school dropout, so they coached me as to how to pass the New York State GED test. And I passed it.

And then, I had the G.I. Bill at age 20. So I applied to West Virginia State University and was accepted.

Berkowitz:

So, now you're out of the Air Force?

Toby:

Yes. I entered the university in 1956, and I graduated in 1961 because I ran into difficulty paying my tuition in the second year, and I had to drop out for a year.

Berkowitz:

Even with the GI Bill?

Toby:

Yes. It wasn't the government's fault. I was a poor manager of my money, and so I worked at the veterans' hospital in the Bronx that one year. And then I went back, and I graduated in 1961.

Berkowitz:

As I understand it, part of your degree was in Spanish? Is that right?

Toby:

Yes. I actually had a double major in psychology and Spanish.

Berkowitz:

That's an unusual combination. What was the Spanish about?

Toby:

I was majoring in psychology and I was an A student in the Spanish course. The Spanish teacher at West Virginia State University was African American. And most of the students in my class were white. She was so proud that I, as an African American, was an A

student in Spanish. She said, "You ought to take a double major." And I did. And so, I graduated with a degree in Spanish and psychology.

Berkowitz:

I guess, in those days, too, Spanish was just kind of coming into use big-time in New York City.

Toby:

That's right. It turned out to be an unbelievable asset for me later on because I got work in Puerto Rico. But at the time, it was kind of esoteric. But I had a degree in Spanish... Then, I decided I would go to graduate school and get a masters in Spanish and become a U.N. interpreter.

I was totally unaware that in 1956 and 1961 all doors to professional jobs in the private and government sectors were closed to Blacks. And so my university guidance counselor said to me, "I think you're off base. You are black, and you'll never get into the Foreign Service." This was 1961, so he said to me, "It's a pipe dream. Forget about it. With a Spanish major, you will be barred everywhere except to teach." And so, he suggested I should go into social work which was a liberal profession and I could make a difference in helping others.

Berkowitz:

And you went to Adelphi eventually, right?

Toby:

Exactly; it was a God-send.

Adelphi University gave me a fellowship for two years and I got my degree in social work in 1963.

I used that social work degree to work for two years in the New York City Department of Social Services.

Berkowitz:

Doing intake interviews with ADC clients, or what kind of work?

Toby:

Well, because I had a master's degree, I was treated sort of specially. They gave me a specialized case load dealing with mostly Jewish refugees from World War Two who lived on the Lower East Side, for the most part. These Jews had been in Nazi concentration camps. I worked with the Jewish refugee agencies, as well, for the first year. In the second year, I worked in foster care. And then, I decided that I should do something different. And I got a job at the National Urban League.

Berkowitz:

Let me ask you another question about these Jewish Holocaust survivors and refugees and so on. Were they were going to get general assistance? Or were they going to get Aid to the Elderly? What was their benefit?

Toby:

It was a special refugee program. The federal government contributed to funding it, but it was state funding as well because these were Holocaust survivors. They carved out a special program for refugees.

Berkowitz:

That's an interesting little niche I had never heard about before in the social welfare system.

I know that you eventually, as you mentioned, went to work for Whitney Young and the Urban League. I am curious how you met him or came into contact with the National Urban League.

Toby:

I was told by a friend that the National Urban League (NUL) was looking for young blacks with professional Masters Degrees in social work. At the time, the NUL was a prestigious interracial organization. I applied and I got the job. In those days, I was very naïve and I didn't know that Whitney Young had just taken over the National Urban League, and had fired the old staffers because he wanted to bring in what he called "Young Turks" due to his belief the Urban League had become sort of staid, so to speak. Before Whitney Young, it had been sort of a refuge for very well-educated blacks and an interracial organization with lots of whites also as professionals there.

Whitney Young realized the Urban League had traditionally been a repository for very upper-class blacks with degrees from the top schools -- Harvard, Yale, Princeton; they felt very special. Even though they were excluded from white jobs, they felt very special. They were very lazy [laughs]. And so, Whitney Young decided to clean house. And he wanted to bring in Young Turks. He brought in me, Johnny Parham who was an outstanding Morehouse graduate with a Masters Degree in Social Work and Ronald Brown, who became head of the Democratic Party and Secretary of Commerce in the Clinton Administration. Sadly, he was later killed in that terrible plane crash in Croatia.

Ron Brown and I were the first two Young Turks he brought in. I was there for about two years and had made quite a mark there because Whitney considered me to have fulfilled what he had anticipated. That is, I became the Training Director for executives in our 56 affiliates and he was supportive of my training methods designed to create executives capable of dealing with a changing country both culturally and politically.

Berkowitz:

These are African-Americans who wanted to work in the private sector?

Toby:

No. Actually, it was to train urban leaguers to run our local offices in cities located in major urban cities. They were facing a new environment in which doors were being opened by President Lyndon B. Johnson in the private sector and government at the senior management levels but our local executives were not equipped to deal with expanded

opportunities for Blacks such as the need to develop a skills bank to meet the needs of private corporations.

So their job was changing and there was a need to find those young blacks in their local communities, get them in the door at organizations that would welcome them. But, again, these young executives who ran the local offices were not well trained. Whitney Young had a dream that they would become first-class executives. For me to do that, Whitney sent me off to Boston University one day a week. Every week I flew to Boston, to B.U., to be trained to be a leader, and how to run a meeting, how to write an effective memorandum, how to give stump speeches, how to organize conferences. All of this, Whitney taught me so that I could pass that on to the local people that we were trying to train.

And then, one day, the telephone rang in 1968, I was asked by the director of human resources at the National Urban League in Manhattan, where I was working, if I would do her a favor. She said, "Would you go to an interview at HEW?" The U.S. Department of Health Education and Welfare had a job, a professional GS-14 job. They had five white males who had qualified for the panel to be selected. In those days, President Johnson had put in place an enforcement mechanism to assure that his executive order for equal employment opportunities would be effective. As you may remember, each Federal agency had given the Civil Rights Office sign-off before any job was filled because, as you can imagine, in 1968 all of the manager jobs in HEW in the New York regional office were all white males. The goal of President Johnson was to open that up. And he did. The executive order was backed up with specific processes, where if you had a panel of eligible individuals for a position, and it was a management position, it couldn't be a lily-white, all-male panel if qualified Blacks could be found.

And it worked. The legendary Regional Director Bernice L. Bernstein at the time was unable to get a sign off on this job for the White male she wanted to hire. I later learned he was David McNally, a Princeton University Woodrow Wilson graduate; He later got a job in Medicaid in Baltimore where he had a distinguished career. Anyway, the Regional Director was Bernice Bernstein. I don't know if that name means anything to you.

Berkowitz:

Bernice Bernstein, yes. Yes. She's very important in the history of public assistance.

Toby:

You better believe it. She was on the team that wrote the Social Security Act in 1935. . The job I got with her was special assistant to the Regional Director for coordination. Factually, the title of this job was "Coordinator for the Implementation of Medicare and Medicaid and external coordination with other Federal agencies such as HUD and Labor. The upshot is that I went for that interview to help out my friend. And Ms. Bernstein hired me. She chose me for two reasons. One, my qualifications were even superior to some of the other candidates, except David McNally who also had a Master's Degree as I had. Two, she was being judged by her Washington superiors because she was presiding over a glaring non-integrated office in 1968 in New York City. By the way, Washington in those days looked at racial/white/black hiring numbers. And so, she got credit for hiring me, a Black male.

I became her assistant for about three years working on the management side of Medicare and Medicaid implementation. I ended up from there going into SRS (Social and Rehabilitation Services) as Deputy Commissioner. But for those three years, I was responsible for monitoring the BHI (Bureau of Health Insurance), which was located in the Social Security Administration in those days, and monitoring SRS in terms of program implementation because the Regional Director was responsible, in those days for the performance of Federal agencies in HEW.

Berkowitz:

For the implementation of Medicaid?

Toby:

And Medicare. In '68, when I started, Medicare and Medicaid were two years old and they were just getting off the ground. But the Regional Director internally was responsible for monitoring the progress of Social Security to implement Medicare, in terms of enrollment and everything. She got daily reports from me and the bureau directors, statistics and all of that. She was also responsible for Medicaid -- that is, monitoring SRS as SRS worked with the states in Region II, which was New York, New Jersey, Pennsylvania, Connecticut, and Delaware. My job was to do the daily monitoring of Medicare and Medicaid implementation and to be blamed by her if Washington was not happy with the state enrollment of Medicaid in particular.

While doing my job, I spent a lot of time with the SRS Commissioner. And he offered me a job.

Berkowitz:

And who was that? Do you remember who that was?

Toby:

Yes. Elmer Smith. He was considered the boy genius of HEW, when he came out of the Maxwell School and Harvard School of Public Administration the late '50s. He was a graduate of Syracuse School of Public Administration and also spent a year at Oxford University in England where he met his wife, a young music student from the state of Georgia.

Berkowitz:

Yes. The Maxwell School.

Toby:

The Maxwell School, right. And from there, he went to HEW where he was a budget whiz rising to become the administrative officer of HEW at the tender age of 26 or 27. From there, he came to the attention of the people in SRS. And he became the SRS Regional Administrator in Charlottesville, Virginia.

Berkowitz:

I believe the first head of SRS might have been Mary Switzer.

Toby:

Yes, Mary Switzer -- he worked for Mary Switzer as her administrative officer.

Berkowitz:

And she had come from the rehabilitation program -- Vocational Rehabilitation. But she got along very well with John Gardner.

Toby:

That's right, very close. She was a legend and very close with HEW Secretary John Gardner, who had come from the Carnegie Foundation.

So, Elmer Smith was Mary Switzer's administrative officer at a very young age. And then, she promoted him to become the SRS Commissioner in Charlottesville, Virginia. Nixon becomes president.

Berkowitz:

In 1969.

Toby:

Right. And in 1969, one of the first things he did was to streamline or to reorganize the federal government, as you know, particularly the regional structure. Nixon's Administration created 10 regional offices -- it was called the Ash Commission.

Berkowitz:

Right. It was one of the commissions that was supposed to make the government more efficient.

Toby:

Exactly. The Ash Commission came up with the idea of ten regional offices, and one was Philadelphia.

Elmer Smith was asked to create the Philadelphia regional office. And he did such an extraordinarily good job, Mary Switzer sent him off to New York as a reward, GS-16. And he became the Regional Commissioner.

Berkowitz:

I guess that's the biggest assignment of regional commissioners.

Toby:

Yes, it was the most important job in the field. So, he became the SRS Commissioner in New York City.

I met Elmer doing the implementation of Medicaid. He was one of the persons I had to monitor. I established a great relationship with him and he offered me a job as his Deputy Commissioner of SRS, which was an extraordinary thing at the time. That was in 1971, when I became Elmer's Deputy Commissioner. In 1974 he got promoted and went to Baltimore to become the Assistant Commissioner in the Social Security Administration in charge of policy and planning in Social Security.

I took over in 1974 as the Regional Commissioner for SRS, running Medicaid, public assistance, vocational rehabilitation, social services programs and aging.

Berkowitz:

And welfare, too?

Toby:

Yes, absolutely. AFDC (Aid to Families with Dependent Children), the social services, the old age services -- I was also responsible for the elderly programs. It was an awesome job

Berkowitz:

1974 is also the year that SSI (Supplemental Security Income) is coming into existence which was quite a difficult thing, as I recall.

Toby:

Yes, it was very difficult. At the same time, they took over our old age assistance program.

Berkowitz:

Right. And so, the welfare bureaucracy is sort of rationalized again, changed around a bit?

Toby:

Exactly. That was an extraordinary and profound change because (Daniel) Moynihan who was ran the Domestic shop in the White House had wanted to have a guaranteed income for poor and disabled people -- that was his proposal.

Berkowitz:

That was his proposal -- though never passed -- Family Assistance Plan, which substituted a guaranteed income for much of traditional welfare, but it did lead to Supplemental Security Income in 1972.

Toby:

Yes. I had a lot of poor relatives in Georgia. And they went on SSI, and they stopped asking me for money after that to help with the shortfalls.

Berkowitz:

[Laughs] Well, that's good. So, 1974, then, you're working with SRS, and you're working with Medicaid. Many federal things are national, whereas SRS programs are state and local and federal.

Toby:

Yes and in those days, as you probably know, the regional office ran Medicaid with huge decentralized authority. There was a clear delineation of authority between the Washington central office/regional people. Washington was in charge of policy for Medicaid, but since Medicaid had no policy in those days, the policy was made up in the regional offices between the state and the regional staff.

Berkowitz:

Or the policy is made up also in the states, right? Is that correct?

Toby:

Yes, of course. You had state discretion; it was a program with dual responsibility by State Governments and the Federal Government. From 1966, when the program was implemented to the early 1980s, Federal Medicaid law and regulations were anything but prescriptive and the lack of Federal regulatory details made my job very difficult and for the states as well. Because we lacked clear rules, when there were fights with states over difficult points of reimbursement policy, the regional office often made up policies on the run.

Yet, we were vigilant in protecting the Federal purse strings and that led to high tension with the states like New York in particular.

Berkowitz:

So, that's a difference between Medicare and Medicaid. With Medicare, the Bureau of Health Insurance at Social Security Administration is making policy, to some extent.

Toby:

Yes. Beginning in 1966, Medicare made national policy with specific detail requirements but doctors in particular did not have to follow the billing requirements. For example, in 1966, BHI published the form SSA-1490 that the doctors could use to bill Medicare, I say could because the doctors could also bill the patient, collect fee, and the patient would have then have bill Medicare. Or the doctor could submit the 1490 but not take assignment. The patient would pay the doctor (no limit on what the doctor could charge) and the program would pay the patient.

Anyway, I recall that the Medicare oversight requirements in the regions beginning from 1966 to 1969 were very lax because the regional offices were told that their job was just to pay the bills. The emphasis was on enrollment and letting the Medicare contractors have broad latitude because as you recall Medicare's structure and operation grew out of a compromise with the concept of a limited Federal role beyond paying the hospitals and doctors in a timely manner.

The result was fraud among the providers and other abuses and then Medicare began to tighten program management. Their policies became more rigid and detailed the policy people in Baltimore operated under very structured rules. Medicaid didn't have that in the early years.

Berkowitz:

As I recall, the Medicaid program in New York was particularly controversial, too: expensive and lots of political disputes about it. Is that right?

Toby:

You got it right. It was extremely controversial, so controversial that the Republican conservatives from upstate New York who controlled the New York State Senate were the major drivers for Medicaid reform and principally responsible for improved management of the program, which had been locally-administered and poorly managed. The state was

powerless to control the Medicaid program as the counties were so powerful. Nelson Rockefeller was governor and his Commissioner of Social Services Steve Berger finally bent to the will of the senate conservatives and my SRS office and computerized the programs and engineered state take-over of the management of the program around 1977. In 1988, President Reagan awarded me the Presidential Meritorious Award of \$10,000 for this Medicaid transformation and saving over \$200 million during the first year of the computerization.

Berkowitz:

Right.

Toby:

The New York State legislature was controlled by Republicans. And as a result, they were able to go to Washington, and they were partly responsible for the 1967 amendments to Medicaid because of, as you said, the controversy. The cost was increasing so much that it was of great concern. And also, there was so much fraud and abuse in the early years.

The program was not computerized in any way -- not for eligibility or payment. All the state did was pay bills, and those bills were, many times, fraudulent. So there was a lot of controversy, as you said.

Berkowitz:

Did you spend a lot of time working with Health and Hospitals in New York City?

Toby:

Yes. Medicaid was the principal financier of the Health and Hospitals Corporation because they dealt with the poor population. And as a result, maybe about 70 percent of all their funds came from Medicaid.

Berkowitz:

So, it sounds like Medicaid now is becoming an important concern of yours, which leads to the next big bureaucratic development, which was the creation of HCFA when Jimmy Carter got to be president, in 1977. You went to work for HCFA relatively early in that agency. Is that right?

Toby:

Well, I believe I was the first appointee after Secretary Joe Califano took a special interest in HCFA, which was his creation and he knew the regions were important.

As you may remember, when HCFA was created in March of 1977, all the senior program managers lost their jobs who worked for the impact agencies, like the SSA Bureau of Health Insurance for Medicare, and SRS in my case. All of us woke up one morning, and had no jobs.

HEW Secretary Joe Califano was a visionary and he knew the nation was ready for national health insurance and so he created a new agency that consolidated the health financing arm of the Department.

Berkowitz:

Right, and brought together Medicare and Medicaid.

Toby:

Exactly. He knew that an agency combining Medicare and Medicaid needed to have people with new skill sets, people with leadership potential, to run the 10 regional offices, as well as to manage the bureaus in Washington -- that is, the Medicare bureau, the Medicaid bureau, within the new HCFA. So, he personally was active in choosing who would be the regional administrators in the 10 regions. And I was the first one selected.

Berkowitz:

To work for HCFA?

Toby:

Yes. The agency was created in March of 1977. I was appointed around May of 1977. It took him a couple of months to decide on who would get the jobs. Of the 10 jobs, only 3 members of SRS survived, myself, Gene Hyde of Kansas City, and Frank Oshida in Denver.

Berkowitz:

I'm trying to get a sense of the regional setup that HEW would have had. There is a regional person, the head of the whole office, right? I don't know what that's called -- a regional commissioner? And then, various program people are going to report to that person. Do I have that right?

Toby:

Well, let me go back just one step. In the regional office, you had Bernice Bernstein. She was the Regional Director. And she reported directly to the Secretary of HEW in Washington.

And then, below were the program managers: Commissioner of Social Security; Commissioner of SRS; Commissioner of Education; Regional Administrator of Public Health.

I was in SRS, so I had reported directly to Robert Fulton in Washington the SRS Administrator and when HCFA was created I reported directly to Bob Derzon, the new agency head and later to Len Schaeffer who succeeded him.

Secretary Califano hired Bob Derzon. And Bob Derzon lasted for maybe a year.

Berkowitz:

Right. He didn't last very long. I think Califano wasn't pleased.

Toby:

Yes. After about nine months, he and Califano had a disagreement. Derzon was a very strong-willed person, demanded respect. And Joe Califano was equally strong-willed and perhaps did not give Derzon the respect he thought he deserved. And Derzon resigned. I

knew Derzon very well from New York. He had been one of the creators of the Health and Hospitals Corporation under the administration of Mayor John Lindsay.

Berkowitz:

He was a friend of yours? He was a contact of yours?

Toby:

Yes, I had known him in New York. I woke up one morning and he was in Washington heading up the new HCFA. That was great for me and the agency.

Berkowitz:

Right. Whereas Len Schaeffer was a budget guy, I believe.

Toby:

Len Schaeffer had come from Citibank to HEW. Califano found him -- I think Len Schaeffer had worked in the campaign for Jimmy Carter. And so, he became Assistant Secretary for Management and Budget under Califano. And then, when Derzon left, Schaeffer became the HCFA administrator. He was some whiz kid -- truly a brilliant administrator who was a demanding boss. He seemed to have an endless capacity for hard work and getting things done.

Those days, as you may remember, there was no congressional approval of the HCFA agency head. So, Califano appointed Schaeffer.

Bill Roper was the first one that faced congressional approval because by then Congress had become alarmed that the head of HCFA, who controlled such a huge budget, was appointed by the President without Senate confirmation.

Berkowitz:

So, you stayed in that office in New York for a while as the director in New York of the regional HCFA office. We hear a lot about the people that were Administrators, like Len Schaeffer or like Gail Wilensky, but we don't hear so much about the regional setup. And I was wondering if there were Administrators who worked in Washington and Baltimore that were more sensitive to the local problems than others.

Toby:

I have to say, with great pride, that the central office of HEW and then HHS were guided -- in terms of looking at the regions -- by national policy coming out of the White House that, in the 1960s and 1970s, pushed for decentralization. And that gave the regional offices enormous power and authority.

That changed in 1977 when President Jimmy Carter was elected. Why did it change? It changed because Jimmy Carter had been Governor of Georgia. The dynamics were that he felt frustrated in terms of the management of his state Medicaid program and the strong influence of the regional office in Atlanta. According to Virginia Smith, my Atlanta colleague in SRS, Carter felt that the regional office had been too rigid in applying federal Medicaid regulations and monitoring his Medicaid program and had been especially

inflexible in approving many of his Medicaid state plans the regional office believed were not compliant with Federal regulations.

Carter went to Washington very much like what happened with Bill Clinton later on. And I can tell you that story too. Jimmy Carter went to Washington with the idea that he was going to reorganize the federal structure because of the way he had been treated by the regional office. Regional Director Ms. Bernstein became a casualty in New York because she was a career civil servant but Carter decided to politicize the civil service replacing her with a political appointee named Cesar Perales. He did not politicize the program agency heads in the field. But he did politicize the regional director job, which sent a signal throughout the agencies, as you can imagine. And so, he also began the process of centralizing program authority in Washington and Baltimore regarding the Medicare and Medicaid programs.

Berkowitz:

Interesting. He was the first governor since Franklin Roosevelt to be President. I guess that has a different consciousness. It became common after that, but he was the first one. And it's an interesting observation.

Toby:

It tells you the importance of relationships. I was stunned -- I had taken some very tough stands against New York State for their poor management of Medicaid, for their inability to put in place good management systems to control fraud and abuse. I had been very tough with New York. And to my astonishment, when the Carter administration took over in 1976, the state commissioner told me that he'd gotten a call from Washington asking about his relationship with me. And so, while I took major -- and I think, in my own judgment, courageous -- stands against New York, which was so powerful in the national system, that is, to make them computerize their Medicaid program, for example, under the threat of taking away their funding, the state commissioner told Washington I was fair. Thus, I got support for that from Baltimore and from Washington as well. In the end, the Commissioner told me that he had said that one of the things he liked about me was that I was a fair administrator. That saved my job because I had no idea that Washington would ask a state Commissioner that I'm responsible for oversight and monitoring, how did he get along with me?

Berkowitz:

That was a fortuitous thing.

Toby:

Absolutely. It didn't change my behavior. I was aware that what I had learned at the Adelphi University Social Work School was really to build relationships with people. If you have a relationship with people, you can get through the difficult times when you have to make very difficult decisions.

Berkowitz:

Let me ask you now about your promotion in 1992, when George H. Bush was President and Dr. Leon Sullivan was Secretary of HHS. You got to be the Acting Administrator of HCFA. Can you tell us about that?

Toby:

I'm delighted to talk to you about this because Dr. Sullivan published his memoirs about six or seven months ago. He talks about this question you just asked. This is what happened. When Dr. Sullivan was appointed as Secretary, the people in HCFA all assumed that because I'm African-American and he's African-American; I must know him. This was a reasonable assumption because of my reputation as a networker and because I was widely known not only in New York but nationally as a former member of Whitney Young's team at the National Urban League where I had national responsibilities. Furthermore, the HCFA Administrator in New York operated in the media capital of New York and was the subject of wide publicity both bad and good regarding the performance of the Medicare and Medicaid programs.

Further, many of New York professionals in New York went to Washington and were in charge HEW agencies in the '60s and '70s. So, everybody assumed that I knew Dr. Sullivan and that Dr. Sullivan knew me. I joke about it, that people think that all black people know each other. But I did not know Dr. Sullivan.

Berkowitz:

Ah, so, he was an Atlanta person?

Toby:

Exactly. I didn't meet Dr. Sullivan until he had been in his old job for two years. He came to New York to give a speech at Harlem Hospital. One of his key aides had been Len Schaeffer's top aide, Jackie White.

She had told Dr. Sullivan that when he was going to New York, he definitely had to meet me and if he was going to Harlem Hospital to give a speech, I should be with him because I could introduce him to everybody that he didn't know, and that I could also give him the kind of in-depth briefing about the institution, Harlem Hospital -- things that he wouldn't find in any briefing book. He said okay. I met him at the airport, and I went with him on that visit. I rode with him to Harlem Hospital, which was about 15 minutes, as you probably know.

Berkowitz:

Right. Just over the Queensboro Bridge.

Toby:

Right. And in those 15 minutes, he and I covered a lot of ground. We discovered we were both from Georgia. Even though I was raised in New York City, I was still a Georgia boy to him. And he was an Atlanta boy despite spending his professional life in Boston. And he had taught at Harvard. And my Masters degree was from Harvard's Kennedy School, so we talked about Boston. I asked him questions about OMB Director Richard Darman, especially how he was getting along with Richard Darman. And Darman, as you know, was Director of the Office of Management and Budget.

I told him that Darman was my advisor at Harvard, which surprised him. I then gave him some clues as to how he might improve his relationship with Darman because I knew how

Darman operated. He appreciated that very much. That started a very good relationship. He began to use me as a back- channel on issues and that strengthened our relationship.

In 1991, he was supposed to head a delegation and represent the United States at a conference in the Ivory Coast, Africa. He had helped plan the first African-African American Summit held in Abidjan, meeting with five African heads of state. And at the last minute, he couldn't go because President George H. Bush directed him to appoint someone else because there was a major issue before Congress dealing with appropriations bills relating to HHS. And so, to my astonishment, Dr. Sullivan talked to the President, and he agreed to let me, a regional agency head, go to Africa on Air Force Two for 10 days, for that first historical meeting. It was history and I could not believe I was there to witness the event with over 100 American Black leaders including Mrs Martin Luther King and Jessie Jackson, Reverend Louis Sullivan of Philadelphia who was the architect of the gathering.

Soon thereafter, I got a call from him saying, "Have you heard that Gail Wilensky is leaving to go to the White House?" And I said that I had heard about it. As a matter of fact, she had told all of us that she was leaving. I suggested to him that Lou Hays, a top notch administrator, would make an excellent Acting Administrator until he could find a political appointment, working with the White House, of course. Lou Hays was a career civil servant. He was actually in charge of the regional offices. So, I reported to Lou.

Dr. Sullivan said, "That's a very good suggestion." And he hung up the phone. Two days later, on a Sunday, he called me at home and said, "I would like for you to come to Washington to be Acting Administrator for maybe two or three months." And I agreed to do that after a lot of cajoling from him because I was not excited to go to Washington when I was in New York with so much freedom in terms of autonomy to do my job. Not only that; I was responsible for the financing of health programs in Puerto Rico and the Virgin Islands.

It was the coolest job in the federal government. And nobody would give that up to go to Washington, work seven days a week, 14 hours a day. But I agreed to go because Dr. Sullivan cajoled me into going. He said maybe for only two or three months. He talked to the White House; they approved it. And I ended up being there 18 months. Fortunately, my wife, Diane, eventually supported my decision. Otherwise, it would have complicated my life beyond what God pre-ordained.

Berkowitz:

Wow.

Toby:

So, my wife was not pleased.

Berkowitz:

Because she's still living in New York?

Toby:

Yes, but she came down every weekend, actually. But that's how I took over from Gail as she went over to the White House.

Berkowitz:

Now, was Gail kind of a shadow Administrator of HCFA from the White House, or was she totally involved in the White House stuff and sort of removed from the agency?

Toby:

When she left, the belief was that she would be in my hair every day. But that never happened, to her credit. I had breakfast with her a couple of times, breakfast meetings with her to let her know how things were going and that sort of thing. But to her credit, Gail never interfered with my administration of HCFA.

Berkowitz:

So, as the Acting Administrator of HCFA, you don't really know how long it's going to be, but presumably short-term. Did you have priorities?

Toby:

Yes. I'm glad you asked that question. When I went to Washington, the first thing I did was meet with the senior staff. I said to them, "I don't know whether I'll be here one month. I don't know whether I will be here three months or six months. But I want you to know that, starting today, I am managing this agency as though I'm going to be here forever." If I had not done that and set the tone, I would have been seen as a transitory figure. And one of the things I learned at the Kennedy School was the importance of the media in public policymaking. And so, I told my person in charge of public affairs -- I said, "Look, I want to meet with the Washington media." And I was told, "It's a bad idea." And I said, "No, I want to meet with the media. Tell me, how do I do this?"

I was told there was a Tuesday meeting in which the press meets every week. The agency heads go in, and they talk, and all the key people -- Washington figures met with the media. So, against the advice of all my senior staff, I met with the Washington media. This was, like, in my third week. I basically told them that I was going to be Acting, but I was going to act as though I was not Acting and that I had a policy in terms of dealing with the media, and I wanted to tell them what it was. Number one, their freedom of information, FOIA, requests would be handled in record time. Number two, I made it very clear, my door was open to them at any time. They were a bit astonished. I told them that I would make sure that they got press releases on key things that were happening.

When I finished my speech, which was maybe 20 minutes, *The New York Times* reporter Bob Pear came over to wish me well. The person for *Modern Healthcare* said she was so impressed, she put me on the cover of *Modern Healthcare* the next week. The *Washington Post* reporter said, "I think I'm going to do a profile on you." And all of this, it's just incredible what happened. The whole 18 months I was there, we never had leaks out of HCFA. Number two, the press always gave me the benefit of the doubt when there was some question on a policy. They knew I would not lie, as well. And so, I had an incredible relationship with the press.

Let me tell you what I found in the agency when I got there, if you're interested in that.

Berkowitz:

Yes.

Toby:

I knew some of this before I left New York. When I got to Washington, I found a completely demoralized HCFA staff. Rightly or wrongly, the senior staff expressed dismay that, during her tenure, Gail Wilensky -- whom I respect, and she's a friend of mine -- but they argued that she had managed the agency with her own small coterie of trusted aides and that she kept the senior staff out of the policy-making loop. The feelings ran so deeply, I had to focus on that issue immediately, at the expense of other issues because an agency is only as effective if there is a contented staff who believe their work is important and appreciated. And so, that was the first thing I found. And that was a serious challenge, believe me.

I quickly decided that I had to give this priority, and I brought in a consultant to help me improve the morale of the agency. He recommended to me that we would do a strategic plan. HCFA never had a strategic plan. So, we formulated a strategy for a strategic plan, and that got the staff involved and got them centered on that. We spent about six months on the strategic plan, laying out our priorities, determining who the customer of the agency was because no one could agree on that before. We all thought it was hospitals; some people thought it was the doctors. I basically said, as a social worker and a public administrator, that the customer was the Medicare and Medicaid beneficiary. And so, we built our strategic plan around that.

The second thing I found was that the reputation of HCFA was one of terrible customer service. The stakeholders, Congress, Secretary Dr. Lou Sullivan, all approached me on my very first week, requested I give priority to improving the image of HCFA. It was terrible. By the way, Dr. Sullivan told me that whenever he went out to give speeches, he was hounded by physicians complaining to him at every medical conference, every meeting; the doctors accused HCFA of gross abuse of authority and said that HCFA was prone to over-regulate.

And the third thing I found was that -- and this was a hot issue -- there was uproar in Congress about Medicaid maximization with states using schemes such as donations and provider taxes and intergovernmental transfers.

Berkowitz:

Yes, using those as a way of increasing the amount of money they would get from the federal government to pay for Medicaid.

Toby:

Yes; it was a hot issue. I had to go up on the Hill three or four times to testify on states scheming and causing fear of bankruptcy of the Medicaid program, which you know can't go bankrupt because it's really off-budget. But you have to match every dollar the state gives you if it's for legitimate services. That was a major issue. I spent a lot of time testifying before Congress. But I got the staff to come together with stronger regulations regarding donations that the states were using from private hospitals and from private groups to match Medicaid funds. We tightened up the regulations tremendously. I felt very proud of that.

The other thing on my desk waiting for me was that hot Medicaid Waiver Oregon plan. When I say “waiting for me,” it actually had already been on the desk of Secretary Sullivan for about a year. But it was on my desk as well because Dr. Sullivan had not approved the waiver because it was so controversial.

Oregon had developed a long list of medical interventions based on cost and effectiveness. The way it worked was that the more useful the intervention, the more likely it would be included in their list. They considered pediatric interventions to be effective. And so, that scored well. But if you had a cosmetic procedure, you scored badly. But the plan was considered unethical. It was considered immoral. And so, the White House held up the project, would not let Dr. Sullivan approve it. When Clinton won, Donna Shalala became Secretary. She approved that Oregon plan within two weeks. And then, I had another big issue on my desk. That was finalizing the plans with GSA (the General Services Administration) to co-locate all HCFA employees.

Berkowitz:

This was about the plans to create a new headquarters that would bring together a pretty widely dispersed agency at that point?

Toby:

Yes. The HCFA staff was scattered in nine different locations in Woodlawn. And we consolidated them, as you just said, into a single site. We got 57 acres of land in Woodlawn. And they got a state-of-the-art facility with a child care center, cafeteria, and fitness center. And we got 3,156 parking spaces.

Berkowitz:

That really does stand out as a government facility even today-- such a nice place out in Woodlawn. I'm surprised that there wasn't a congressman that said, "This is a little too elaborate for government workers."

Toby:

Well, you are very perceptive and insightful here. You know how we avoided that? We avoided that by not allowing GSA to give us the facility. Unlike the CIA, which has their facility in their name, we were able to negotiate that GSA would keep that center and rent it out to us.

So, even today, GSA runs that facility. It's CMS's facility, but in terms of ultimate authority, it's under the GSA administration, even though they don't do the daily administration. It's on lease to HCFA.

But that has allowed HCFA to avoid the congressional complaint about federal employees having a decent place in which to work.

Berkowitz:

There's one other issue I wanted to ask you about that Gail Wilensky had been working on, and it was quite controversial. That was the payment to doctors, the new scheme for paying doctors under Medicare. Did you get involved in that at all?

Toby:

I think that is where I got very lucky. To her credit, Gail spent an inordinate amount of time fashioning that legislation, shepherding it through Congress, and then implementing it. So, when I arrived in March of '92, it was complete. And consequently, the doctor payment issue was something I didn't have to deal with. It had been done.

Berkowitz:

The new resource-based relative value scale was already implemented?

Toby:

Yes. It was a fee schedule for doctors.

But I had so many other issues on my plate. When she left, one of the key issues was the decision to release the controversial hospital mortality data.

Berkowitz:

Which listed hospitals by name?

Toby:

Yes, I can't tell you how controversial that was, especially from the hospital associations. But we got that done. Gail had started that movement, and I was able to complete it.

The other thing was implementing regional specialist contractors for the durable medical equipment and renal dialysis, which was designed to curb Medicare fraud or abuse. Before I got there, the durable medical equipment and renal dialysis for end stage renal disease -- this was all managed by the Medicare contractors. We came up with an idea that, since this was a highly inflammatory part of the system, in terms of abuses and so much fraud, we should single them out and streamline their administration. So, we implemented a concept of having specialist contractors that would only handle those claims. We took those out of the general Medicare program administration, away from Blue Cross/ Blue Shield and all of the other contractors. We set up regional specialists to really curb fraud and abuse. I think it worked quite well after that.

The other thing we did -- and I'm very proud of it -- was that we pushed for HMO (Health Maintenance Organization) choice over fee-for-service. When I got there, Medicare enrollees were not interested -- well, Medicare beneficiaries didn't really know about the HMO choice. And so, one of the things I did was push for doubling enrollment over four years of Medicare beneficiaries who would leave fee-for-service and go into HMOs. One of the things I did was to target Medicare beneficiaries who were still working and had coverage from their employers. We would encourage them to enroll in HMOs as a way of saving money and as a way of providing more comprehensive services. I came up, with my staff, with \$10 million to educate the Medicare beneficiaries about this choice. That was something that I was very, very proud of.

The other thing I was proud of was -- you intimated about this before -- in terms of what does a regional person bring to Washington? I brought, for the first time, a regional perspective. I learned from this experience that, if you want to have regions involved in

policymaking, you have to have regional administrators go to Washington and be involved in the policymaking because the inclination in Washington and Baltimore is not to involve the regions in policymaking. You use the regions for operational oversight. But you don't use them for policymaking. When I got to Washington, that changed right away. I didn't have to even push it because when you're in charge, people know your mind, and they come to you and say, "Maybe you want us to contact the regions about this new policy we're thinking about." And so, I was able to get the regional offices involved in policymaking for the 18 months I was there. That worked out well.

The last thing I was extremely proud of was getting Medicaid in Puerto Rico into a better financing system for them. Most people don't understand that under the administration of Medicare and Medicaid, we have territories: we have Guam; we have American Samoa; we have Puerto Rico, we have the Virgin Islands; we have the Northern Marianas. They're out of sight. When Washington is involved in policymaking, they never think about the uniqueness of those territories.

Puerto Rico is huge. It's larger than 25 states in terms of Medicaid and Medicare beneficiaries. On the financing side, I was able to help Puerto Rico Medicaid increase its expenditures because the program operates under a Congressionally-imposed fiscal cap. This doesn't happen with any other Medicaid program in the country. Puerto Rico has 1.2 million people in Medicaid. They're spending \$1 billion annually on Medicaid but receive only \$325 million in federal funding. To cover the deficit, the Commonwealth Government uses local funds. This scenario has been going on since 1967 and thus contributes to Puerto Rico's current fiscal crisis.

So when I got there in '92, I decided to give Puerto Rico \$25 million to finance their Medicaid program. I had been asking for this when I was a regional agency head in New York for months. And nobody would pay attention. When I got to Washington, the first thing I asked for was a legislative proposal. The White House approved it, and Puerto Rico got \$25 million. So, I'm very proud of that, too.

Berkowitz:

So, it sounds like even though you were only there for 18 months, you managed to make a difference. And it makes me wonder why you would want to leave the central office after that, rather than staying there.

Toby:

Well, that was settled by the election. Clinton won the election.

President Bush had already decided that I had made such a mark. Dr. Sullivan had also decided I had made such a mark. They had made it clear to me that they were going to send my name forward to Congress for confirmation after the election to be the Administrator.

But I had said to Dr. Sullivan and his team, "I don't want it. I'm a career civil servant. I am very close to 25 years of service. And I don't want a political job. I want the security of my federal civil service retirement pension." And so, the understanding was, I was not going to stay if President Bush had won the election. But he lost the election. And consequently,

I was concerned as to whether I would be able to return to my office in New York, which I had been promised. And I got lucky for a number of reasons. I got very lucky in the sense that the transition committee for HHS was dominated by New Yorkers, and they were all my friends. I was also aided by the fact that Congressman Charlie Rangel had told the White House that I was a career civil servant, I was a friend of his, and that I should be allowed to go back to my office in New York and retire at the time of my choosing. I was not clear that was going to happen because when I saw on television President Clinton in Arkansas introducing his new cabinet -- I saw this from my television in my office -- HCFA office in Washington. I was watching it, as you could expect.

When it was time for President Clinton to introduce Donna Shalala as Secretary of HHS, he added this comment. "This little lady has the toughest job in government, and I'm asking her to clean up that HCFA as her first assignment." You can imagine my fear.

Going back to the dynamics of regional monitoring of states, Clinton had had many run-ins with HCFA's regional office out of Dallas, Texas, which had responsibility for Arkansas. And so, he, like President Carter, had this animus against regional offices. And so, I got lucky here again. I knew Donna Shalala when she was in New York. She was a very good friend of Congressman Ed Koch. And so was I.

Berkowitz:

She was in New York at CUNY?

Toby:

Yes. But Ed Koch had brought her to New York from Cleveland, Ohio, to first serve on his board -- remember when New York City was about to go bankrupt?

Berkowitz:

Right, the mid-'70s.

Toby:

That's right. And there was an oversight board called the Financial Control Board that Koch had to put together to close the deficit and put the city finances on a sound footing. And he put Donna Shalala on that board. And as you said, afterwards, she went to CUNY.

Ed Koch, before he became mayor of New York City, was a congressman.

Berkowitz:

Right, from Greenwich Village.

Toby:

Absolutely. And his office in the federal building at 26 Federal Plaza in New York City was located one flight below mine, the 38th floor, and he was on the 37th. He used to come to my office when he was a congressman to complain about the Health and Hospitals Corporation and its terrible management. He would ask me, "What are you going to do to clean it up?" This is when I was the SRS commissioner. And we bonded.

So, Ed Koch apparently talked to Donna Shalala. And so, the upshot of the whole thing is that my reputation in New York, my reputation in Washington was such that President Clinton sent one of his top aides to my office to tell me that I would not become the HCFA administrator in the Clinton Administration, but would I please stay in Washington for six more months to help him with his Clinton plan? And so, I was kept on six additional months. And this is when they were negotiating with Bruce Vladeck to come on board. And it took Bruce several months to get approved by Congress.

Berkowitz:

Another New York-New Jersey person.

Toby:

Exactly, and someone I knew very well in New York. So, they chose Bruce Vladeck to come in and kept me there as Executive Deputy. My job was to testify to Congress on Clinton's new deficit budget, and also to select the people from HCFA to be on the committee to implement the Clinton health care plan. So, I got real lucky.

Berkowitz:

And then, you were able to go back to New York City for a while?

Toby:

Yes, I went back and stayed four years, until I had my 31st year.

Berkowitz:

That would have been 1996, right?

Toby:

Yes, '96, exactly.

Berkowitz:

Well, that's quite a career that you had. And this is actually a very interesting side of things that we haven't heard much about. I want to thank you for talking to us.

Toby:

Maybe one of these days, we could talk further -- those Rockefeller years in Medicaid were something we'll talk about next time [laughs].

Berkowitz:

Yes indeed.

Toby:

Those were fascinating years because you touched on New York as having a lot of problems in the late '60s and early 1970s. And I had a lot of run-ins with the Rockefeller administration. But nevertheless, I survived it all.

He was a very liberal Republican but he was also concerned about the prospect of higher costs; he curtailed eligibility and stuff like that. So, I worked closely with Governor Rockefeller and his people to make that program more aware of fraud and abuse and to

de-escalate the cost a little bit. He also brought in good people like Steve Berger and Art Webb.

Anyway, it was a pleasure talking with you.

Berkowitz:

Our thanks to you for your time, for sharing this interesting history.

Interview with Bruce Vladeck

Washington, DC on January 29, 2015

Interviewed by Edward Berkowitz

Transcript edited for clarity.

Berkowitz:

Today is January 29th and we're here in the National Press Club in Washington D.C. My name is Ed Berkowitz, and I'm talking to Bruce Vladeck, who is former Commissioner of CMS, and I guess the --

Vladeck:

Administrator.

Berkowitz:

Administrator, I'm sorry, right. Not the Commissioner --

Vladeck:

Administrator. The Administrator of the Health Care Financing Administration.

Berkowitz:

Right, right. I was going to say you were there for the unveiling of the CMS name.

Vladeck:

No.

Berkowitz:

No?

Vladeck:

No, that was a Republican thing. That was 2001 or 2002.

Berkowitz:

Oh right, okay. Glad to get that clear.

Vladeck:

Well everybody always hated the name of HCFA, and so when the Republicans came in they decided they'd give it a new name. Why they picked the one they did -- I mean, only Republicans could pick a worse name for the agency than it had already. We actually had a new name in mind, if the Clinton health reform had passed. We were going to rename it the Health Security Administration, which would've been a better name, but that died.

Berkowitz:

I guess interest was great in a department that was like, health-centric, to create new health centers... I think that the notion of centers had a good connotation.

Vladeck:

I have no idea. I was not consulted.

Berkowitz:

We've talked before about your career and about your time as the HCFA administrator. I want to talk to you a little bit about your time afterwards and maybe a little bit about what the value added from having been at HCFA was, so let me start with this question. You've done all sorts of things from what I would call a privileged position in the health care policy system. You've done stuff for the Institute of Medicine, the IOM... You've worked at the Robert Wood Johnson Foundation, and obviously worked for the government as well. I was just curious whether you saw this as any sort of rational system. Do you see this world as actually functional in that the IOM has a role, the Robert Wood Johnson has a role, the government has a role, and academia has a role?

Vladeck:

No. I mean, I am continually and increasingly distressed by the extent to which the institutions that are identified as leading institutions in the health care policy or whatever, tend to be both highly susceptible to the latest fads or enthusiasms and also very much influenced by the political currents and eager not to offend those who are in power or who they believe are about to come into power although, obviously there are exceptions. But you know, I think, however many years ago, the Heritage Foundation and the people like that began a pretty conscious effort of taking over the sort of policy debate, and they've been very successful.

Berkowitz:

They've been more successful than the quote-unquote, "progressive side?"

Vladeck:

Well, I don't know who the progressives are. I mean, people have identified Brookings as a left-wing institution. In that sort of world, then, the bad guys have won hands down. And this is combined I think, to some extent, with the hegemony of the market economic types in the academic world, and it's pretty depressing from my perspective.

Berkowitz:

Let me ask you another kind of question about the -- since I've seen you, the Affordable Care Act was passed, and so this is our latest iteration of national health insurance. When I go to the doctor, to my internist, I present my card for my employer has negotiated with some health insurer and, despite the Affordable Care Act, nothing seems to have changed particularly for me as a consumer. Is that a reasonable attitude?

Vladeck:

Well, actually more has changed than you're acknowledging, but that actually was the political goal of the Obama administration and many of their supporters: to try to avoid offending or frightening the people who had relatively good insurance as much as possible, and so to the extent that the majority of us, our health insurance really hasn't changed that significantly as a result of the ACA. That validates, I guess, the wisdom of the strategy. The problem is our insurance, by all measures -- and it's certainly true in my case, I don't

know in yours -- has gotten considerably less good over the last decade in terms of our out of pocket costs and restrictions on the services we can receive and so forth.

And so -- and I think the ACA reinforced that. There's been a hollowing out of private insurance. It's very significant and the small cadre of people who are still doing what I would define as intellectually honest work, like Commonwealth or Kaiser, have increasingly identified it. So we've significantly reduced the number of uninsured people, but the number of underinsured people has grown very substantially, and the ACA doesn't help that. In fact, the design of the benefit -- or the exchange available benefits in the ACA makes it worse.

Berkowitz:

I always had this idea that someday I'd wake up and I'd get a card in the mail, and everybody would take their card to a physician or hospital, but I guess it just hasn't quite worked.

Vladeck:

Well, if you're over 65 it works that way.

Berkowitz:

Yes, that's the one thing we do have.

Vladeck:

Yeah, and not working full-time.

Berkowitz:

One other kind of broad-sided question if I might. Rashi Fein wrote something about how at a certain point health care reform, as we would say today, became a matter of computer printouts and stuff rather than some kind of a passionate or ideological debate. Is that true? It seems to me that leads to another concern which is this complexity of everything: How do doctors get compensated, how do hospitals get compensated, how do these rules work? How does Medicaid work in the state of Utah compared to Michigan? All these things are so beyond the public comprehension that maybe this is a field that is passed on to these sorts of techie types and the Wilbur Cohens of the world will not come back.

Vladeck:

I understand that a little bit. I don't think that's the issue at the moment... I understand -- I didn't hear it, but -- that Uwe Reinhardt gave a very good talk last night about -- and there was just a piece by Kristof in the Times this morning about how -- for a whole variety of reasons, the sort of dream of the Wilbur Cohens of the world and the other people who created Medicare had is not a significant part of the current culture anymore. There's no labor movement left to stoke it.

There's an increasing concern that I think is very justified that sort of the more comfortable, better off members of our society have less and less comprehension of what life is like for everybody else. Again, we've had this enormous ideological effort over the last 20 years to reinforce the notion that if you're wealthy or successful it's because you earned it. It's the only possible explanation; that you deserve it and that the 47 percent or the 57 percent are

poor because they're morally inferior. It was embarrassing for a presidential candidate to get caught saying that, but I think there are a whole lot of people who believe that.

And that's an acceptable part -- and somewhat, if you look at the Indiana Medicaid expansion, look at the Arkansas Medicaid expansion, the Pennsylvania Medicaid expansion, that's the underlying message, that poor people are poor because they're too lazy to work. We hear that more. You didn't hear that over the last 30 or 40 years because everybody knew it was bullshit, but now it's back and the evidence is that it's even less true than it was 50 years ago. It's now part of the currency again.

So I think there's been this very significant shift of public perceptions and public attitudes about all these issues of public policy and I don't fully understand it. I don't totally know where it comes from. But I think a lot of it is the result of a conscious effort to spread those kinds of views and values in the population, and I think it's been sort of frighteningly successful.

Berkowitz:

That's interesting. Maybe one thing that was different was that Wilbur Cohen's father was an immigrant, you know, and so he was very close to that world and other people were close to similar kinds of things.

Vladeck:

Well, you know it's interesting. We've sort of redefined what's progressive and what isn't. Now we're fighting about immigrants and immigration and the people who are pro-immigrant -- it defines a large part of the political cleavage in the country. That's as far as they go. But I mean, I think some of the leadership, particularly of the Hispanic community, is saying, "Look, you know, legal status is one thing, what about jobs and education and all that kind of stuff?" But it's very hard to sustain a debate about that when the mainstream media aren't really interested and Fox News will make fun of you for raising that question. So, you know, it's pretty distressing from my point of view.

Berkowitz:

Let me take you back to when you were in government. When you were at the HCFA. At that time there was a significant expansion of Medicaid and other such things. Looking back on it today, do you think -- is that a building block for the Affordable Care Act? Was it the right thing to do at the time? I know President Clinton tried to pass broader health care reform.

Vladeck:

I think the sort of transformation of Medicaid which was going on when I was there, in terms of my role and my job most visibly through some of the state 1115 Demonstration waivers, laid the groundwork for some very positive changes and the framework, the Medicaid part of the Affordable Care Act. The big victories came just as I was leaving with the enactment of CHIP and the Balanced Budget Act. And it was an enormous fight because in 1995 and 96, the major fight was whether we were going to preserve the Medicaid program as it was structured at all or whether it was going to be turned into block grants, and it was scary.

Berkowitz:

We've turned that corner?

Vladeck:

We have turned that corner decisively, and -- no, well, Ryan's (Representative Paul Ryan, R-Wisconsin) still talking about it. Some of the new Republican leadership in the Congress is talking about it, so it's going to be back. It'll be back in the discussion of the budget this year. I'll bet you money about it. It'll be in the Republican deficit reduction plans, so it hasn't gone away. No truly bad idea ever goes away. That's one of the things I learned in Washington. No truly bad idea ever dies.

Berkowitz:

Does it matter that, there's no -- Henry Waxman (D-California) in Congress at the moment? I kind of associate him with, you know, pushing these little expansions --

Vladeck:

He played the central role.

Berkowitz:

Is there another Henry Waxman that I don't know of?

Vladeck:

We don't know. If the Democrats ever get the chairmanship of that subcommittee back, we'll find out. I think the caliber of the people involved in these issues -- both parties, actually -- is as high as it's been in the past. Henry was an extraordinary historical figure, but I think there are a lot of good people in Congress. I think just the sort of ideological and political environment under which they're operating has shifted so dramatically that, if we get through the next two years without making anything significantly worse, I'll view that as a, as victory.

Berkowitz:

If Robert Ball were still living, he would say, "Well, I've got my eye on so and so."

Vladeck:

No, I think I could identify a dozen members of the House and half a dozen members of the Senate, although the political tide would have to turn a significant way again. These folks would be great leaders.

Berkowitz:

So one thing that I said before that there's not much change in my visit to the doctor. There is actually one change that I and everybody else have to deal with, and that is I've signed lots of HIPAA forms in my day and that's Clinton era legislation --

Vladeck:

The medical records privacy act was sort of an afterthought relevant to the major thrust of the legislation which was the sections on "portability" and its beginning of minimal federal standards for health insurance, or what qualified as -- or what constituted -- "qualifying coverage." It's really interesting because again, it was not the centerpiece of the

legislation; it was not anybody's central focus. What we were trying to achieve was general administrative simplification, which is in the HIPAA law and is again, HITECH Act and it's in the ACA again, which the insurance industry and the now the software vendors have managed to sabotage. But we couldn't have come as far with electronic medical records and so on and so forth as we have, which is not as far as we should be, if it hadn't been for HIPAA and those HIPAA rules.

What this is all about is as a matter of federal law, which it wasn't before HIPAA. You have a right to privacy relative to your medical records and you have a right of ownership relevant to your medical records. That was a change and you know the growth of data breaches and the Internet and Snowden, I mean Americans are much, much more sensitized to this issue than they ever were in the past, and it's still going to be an obstacle to some of the visions, fantasies people have about interconnected health care providers.

We still haven't totally solved the problem with consent. So these forms you sign don't let your doctor share your records with a specialist at another hospital unless you specifically authorize it. So we're not close to being where we should be -- but again, nobody was really paying attention to the issue of privacy of individuals' medical records until HIPAA. I'm not going to say it's perfect or anything, but if we didn't have that framework, the development of some of this technology would've been even further repressed I think.

Berkowitz:

That's interesting that, we could have this system where it's like all this data could be read instantly and so on -- which seems to me, is very far off. I've watched the doctor handwrite stuff, and yet that's so appealing to politicians to be able to say, "Oh, we could save billions of dollars."

Vladeck:

We could, we could. But the private insurers and the big software vendors would lose some of their market advantages.

Berkowitz:

Because they're data managers. They'd lose that.

Vladeck:

It's not always in their interests for their data to be shareable and it's not always in the interest of, -- Epic's gotten the worst reputation of this -- people with Epic systems to be able to communicate with Cerner's systems. Epic wants the people with Cerner to have to buy Epic in order to talk to them.

Berkowitz:

And then the government's not going to come in and say, "Oh we'll do it --"

Vladeck:

You know, the amazing thing is under HIPAA and under the HITECH Act, the government has the legal authority to set all the data standards that would permit real interoperability of medical records. And nobody's wanted to go there because the political pushback would

be too intense -- I mean, it would be an act of political suicide for whoever really tried to do it.

Berkowitz:

I want to, for the record, to follow your career just a little bit since you were the Administrator at CMS.

Vladeck:

I'm a bouncing ball.

Berkowitz:

So there's this thing called the National Bipartisan Commission on Medicare. Tell me a little bit about that.

Vladeck:

While we were working on the Balanced Budget Act (BBA) --

Berkowitz:

Of 19 --

Vladeck:

-- 97. The Republicans, supported by sort of the editorial pages of the Post and the Times and people like that, even before the law was finished, were already making a lot of noise about how what we were going to do in the BBA, while it would provide a short term patch for Medicare's finances and so forth, would not solve the long term problem and we weren't addressing the long term problems. And so the deal was to create this commission that would address the long term problems.

And we spent a lot of time working on the language of that provision, because the draft that came over from the Congress -- I don't remember exactly how it worked -- was very carefully balanced. It had X number of presidential appointees, and then the majority -- the speaker of the House and the majority leader of the Senate would each get a certain number, and then the minority leaders would each get a somewhat smaller number, and at the time the Republicans still had the majority in the House. The Democrats had the majority in the Senate. But we didn't trust some key people. Who was the Majority Leader?

Berkowitz:

Daschle?

Vladeck:

No, it wasn't Daschle. I don't think it was Daschle, because Daschle we trusted, but I don't remember who. Anyway, we really didn't trust Moynihan and Breaux so we played around with it and so forth and we ended up creating sort of a super majority requirement for the commission to do a report. So I think there were 17 members and they had to get 12. For a recommendation to get adopted, it had to be 12.

The commission was very polarized in its members and even though I was a presidential appointee, I think it is entirely fair to say that I was sort of a member of the left wing caucus that was comprised of Jim McDermott, John Dingell, me -- I'm trying to think of who else. Pretty much that was it and Tony Watson swinging back and forth and then the sort of moderates -- it's sort of interesting, the moderates were all the other presidential appointees. Well, Laura Tyson and Stu Altman --

Berkowitz:

All the economist types?

Vladeck:

Yes, but then Stuart really wanted to be the kingmaker to make a deal on this kind of thing. I'll tell you -- do we have time for a story? I'll tell you the best story about this. So, they ran the original numbers and -- the co-chairs were Breaux and Bill Thomas -- and Breaux hired the staff director who was this psychopath, Bobby Jindal. And so they ran all these numbers, they ran all these analyses and they talked about him. The commission started meeting, I think in early -- well at the very end of '97, I think, or early '98 and it was supposed to have its report to the Congress by the spring of '99 so then presumably they could enact something in a non-election year. That was the theory allegedly.

By the spring, it became apparent to all of the Democrats -- and I'm trying to think who were the senators on it. There was Breaux, but there was a Democratic senator who was better from my point of view, in terms of their politics. But anyway, it became apparent to all the Democrats that you couldn't make, given the estimates we were working with and the numbers were working with at the time, better -- you couldn't solve the long term financial stability of the program just by cutting costs. You could cut costs way beyond anyone's imagination. You'd still run out of money because of the demography -- you had to put more revenues into the program.

And so, you know, we were under the open public meetings law or whatever, but we'd have dinner as a commission and do all the real work. And so at the dinners, we basically said, "We're not going to support any recommendations that don't include revenues. We're not going to." And the Republicans said, "We understand the arithmetic, but we can't talk about revenues before the election. Right? This is the spring of '98, -- after the election we'll talk about revenues."

The election comes and goes, and they still refused to talk about revenues. So meanwhile, they're trying to put together a package in which they're creating a drug benefit, which is going to be the tradeoff for premium support as their recommendation. And negotiations are going on back and forth between the White House and Thomas and the Republicans on this side, with Stuart trying to find a compromise. So in January of 1999, we had a meeting of the commission scheduled. And the meetings customarily started late afternoon to accommodate the congressional session. We'd have a meeting from like 4:00 to 6:00 and then we'd have dinner together and we'd meet again the following day.

So Brookings -- and they may still do this, Monday morning -- this Monday luncheon thing where they invite some newsmakers to something at noon, so they wanted to have one on

the Medicare commission. They invited me to come talk and, so I figured, since I was going down to Washington anyway, I'd go early to do it.

So I came down and I spoke, and somebody asked me a question. I just talked about Medicare generally, but then somebody asked me a question about what I thought the prospects were of coming to an agreement in the commission. And I said I was very pessimistic, because it was very clear to a number of us on the commission that you couldn't keep Medicare alive in the long term as a program worth having unless you provided more revenues. You couldn't cut your way, you couldn't save your way to financial stability, and we made very clear we weren't going to support any recommendation that didn't include revenues, and the Republicans refused to even talk about revenues in public. So unless we can break that impasse, I couldn't see how we were going to come to an agreement.

So that was that. Other questions, I leave there and go over to the Russell Building for the meeting, and the meeting was in one of these great Senate rooms. Some fancy room in the Russell Building, where the members of the commission - are around this sort of U-shaped table, and CSPAN's in the middle, and then the staff is around the back. And then the public is seated over this way.

So we're having this meeting, we're going on in the meeting and we're about -- I don't know what time it started, but about a half an hour into the meeting, I can see all my friends and former colleagues in the administration were sitting in the staff seats. All of them, their beepers start going off or their phones started ringing. They all get up and go out of the room. So this goes on for a while, so there's some crisis clearly going on. I think we can name names.

So after about half an hour, one of them comes up to me and sort of whispers in my ear, "Chris Jennings has to talk to you. Can you, come out and take a call?" and I said, "Sure." I pick up the phone, I say, "Chris, what's up?" And he says, "Let me ask you a question." I said, "What?" He said, "Were you at the Brookings Institution at lunchtime today?" I said, "Yeah", he said, "Did you say in order to keep Medicare solvent we needed to increase taxes?" So I said, "I might have." He said, "What do you mean?" I said, "Well, you know, I don't know if I used the T-word or the R-word. I think I said we need more revenues, but I didn't specify what the revenues were, but, I might have said tax, but I think I said revenue," and I said, "Why?" He said, "Well the ways and means committee" -- which at the time, their public relations person was a fellow by the name of Ari Fleischer, "has just issued a press release that you were floating a trial balloon for the administration's request a tax increase in this year's budget." I said, "Oh." [laughs]

I said, "Well Chris, honestly, to keep Medicare solvent over time, you need more revenues. I didn't say we need more taxes." He said, "Well everyone's all up in an uproar around here" and so on and so forth and I said, "You know, I understand." And I said, "Well listen, you know, if I were you" -- Whoever the press secretary was at the time has to go do his daily briefing and Chris wanted to know how he should respond and whatever and I said, "Well that's easy" and he said, "What do you mean?" I said, "Tell them, look, we did appoint the guy but he doesn't work for us anymore. He's obviously lost his mind, what

does it have to do with us?" He said, "No, no, no, we don't want to do that." So I said, "Well you know, if I used the wrong word, I'm sorry"

So I go back to the meeting. There are several more phone calls during the course of the evening that talk about the issue. They're still trying to figure out what to do. The next morning, and I'm awaiting further instructions, so I don't know -- the next morning, as I'm walking through security to get into the Russell Building, the phone rings and it's Chris. He says, "Hi, how are you?" And I said, "I'm fine." And he said, "Well, we were around late last night trying to figure all this out." I said, "I'm sorry." He said, "It's okay and so what we've decided is we're glad you did it." And I said, "Oh?" He said, "Yeah, somebody had to float the idea. "The thing is," he said, "You're right." I said, "I know I'm right." He said, "But nobody else was saying we've got to get the T-word out there, we got to get that idea out there, it's really true." And I said, "Well I didn't know that was the criterion."

And he said, "Well, we're glad you said it. We decided we're glad you said it." I said, "Well, I'm always happy to be of service." He said, "It's just one thing. I want to ask you a favor." I said, "Sure, anything." He said, "From here on in when you talk about these things, would you use the R-word and not the T-word?" I said, "Yeah, I get it. Sorry if I used the T-word, I will use the R-word hence forward." That was the end of discussion.

I've told that story without naming Chris for years, and then I tell the punch line of the story. I get home that night, I think I was back living in New York by then -- no, I guess I was still living in Washington -- I get home and I'm telling my mother who loved hearing stories about life in Washington, and I'm telling her this whole story and in the future it's okay to use the R-word and not the T-word. Without much hesitation she says, "Can I ask you a question?" And I said, "Sure." And she said, "Where does the government get R except from T's?" and I said, "That's a pretty good question. The lottery is the answer." And she said, "It doesn't sound like it's enough money." [laughs] She said, "Maybe we all ought to turn in our soda cans."

Anyway, so the commission blew up basically. Again, all the way up to the night before the last meeting, they were trying to broker a deal in which the limitations on premium support would be sufficiently substantial and the Republicans would support a real drug benefit -- and it never came to pass.

Berkowitz:

This was going to be like the 1982 commission?

Vladeck:

Well that was the original idea. That was what Breaux and Thomas had originally envisioned --

Edward Berkowitz:

Different situation --

Vladeck:

Different situation, people were too far apart. So they got a majority -- so there was a draft report and the draft report commanded a numerical majority of the commission, but not the

super majority that the law called for and so Thomas and Breaux then, in a fit of pique, refused to publish anything, so there was never a report at all. And I've actually seen references over time to the lie that this was what the commission proposed, which was the draft report, which was not adopted. And no one can totally validate it because, if you go to the archives or the internet or whatever, there's no report there. Except the draft, which was a draft, but that was not even recorded that it was not approved. It just sits out there as the draft.

So anyway, that was the commission. But I would say and I ought to get it, there is somewhere -- and I decided I was really fed up, I decided I was really tired of being nice to everybody and I, you know everybody made their remarks about the draft report -- it was the best 10 minute talk I ever gave in my life. I was both angry and focused and I've got to track that down somewhere. It was really good.

Berkowitz:

So you said you're moving back to New York?

Vladeck:

So I moved back to New York. Shortly after I left the government, I took a part-time faculty position at Mount Sinai in New York, Jack Rowe the CEO there at the time, really wanted to recruit me and it was sort of to give me time to figure out whether there was stuff for me to do there that I wanted to do. And so July 1, 1998 I went back to New York full-time. I had a dual role. I was professor of health policy, and geriatrics, and then I was senior vice president of the health system. It was sort of without portfolio for policy -- I was the senior vice president for policy of the health system. But I got there in July of '98, and I was there six years. I worked for eight CEOs.

Berkowitz:

A little turnover?

Vladeck:

And there was a lot of chaos and trouble and so on and so forth which was not entirely my fault, and I got along really well with the first seven. What I did changed from CEO to CEO, but I wasn't getting along so well with the eighth CEO and he was not eager to have me stick around. I had done some sort of speaking stuff for Ernst & Young as a consultant.

Berkowitz:

The accounting firm?

Vladeck:

The accounting firm which was trying to buildup their health care work, was trying to build an academic medical center consulting practice and so I did some of those and it was nice. They paid well and then somebody decided that the auditors from Mount Sinai were in violation of their -- I forget what the word is. Of their, you know, their policies about conflicts of interest or whatever. They don't call it conflicts, what do they call it, all the accounting firms do? Anyway, so they couldn't do that anymore. So I said, "Okay." and they said, "Well, how about you come here full-time?"

Berkowitz:

In the city?

Vladeck:

In the city. So I said, "Well." I said, "I'm a tenured professor and I live in faculty housing," so you know, to make up for what I now have, it'd be very expensive. "What's your price?" So I made up this ridiculous number and they said, "Okay."

Berkowitz:

Wow.

Vladeck:

So I went there and I did that or about a year-and-a-half and I was just starting to get the hang of it, and start to figure out what I was doing and enjoying it. And then I made the biggest mistake of my career, of my life, and I got seduced by John Corzine --

Berkowitz:

John Corzine the Senator, or John Corzine the --

Vladeck:

John Corzine the governor-elect. What happened was -- I'm trying to get the years right -- in the fall of 2005, there broke a series of scandals about the University of Medicine and Dentistry of New Jersey.

Berkowitz:

The company of Robert Wood Johnson's school?

Vladeck:

Robert Wood Johnson Medical School was part of the university. The university was comprised of two allopathic medical schools, an osteopathic medical school, a nursing school, a dental school, a school of allied health professions, a school of public health, and the University Hospital in Newark and the University Behavioral Health system statewide and a few other odds and ends. There was all this stuff going on, and the board started floundering and the recently installed president started floundering around.

And then, as I was told the story, the week before Christmas in 2005, the U.S. Attorney, a gentleman by the name of Chris Christie, walked into the board meeting and presented them with a draft indictment for Medicaid fraud and then another document, which is a draft so-called -- what was it called? The Deferred Prosecution Agreement, where if they agreed to a whole set of conditions and reforms, he would not prosecute them for the Medicaid fraud if they did what there were supposed to, which included the appointment of a federal monitor identified by Christie to oversee everything except the academic actions of the university and a whole bunch of other stuff. It was pretty onerous.

Anyway, the board immediately agreed to it. Because he told them, which was sort of true, but he intimidated the shit out of them the way he does with people, that if they were convicted of Medicaid fraud -- and he had them, which they did, it was piddly stuff -- billing,

actually double billing. Billing for outpatient visits both as physician visits and hospital visits, but -- they would be permanently excluded from Medicare and Medicaid and thereby would be out of business. So anyway, so they agreed to it. This is a reality with which the the governor-elect, who doesn't take office until the middle of January, is confronted. So he forces the resignation of the general counsel, he forces the resignation of the chief compliance officer and he forces the resignation of -- Christie does -- one of the other senior people. And -- but again, most of what happened took place before the appointment of the then relatively new president. Corzine decides one of the first things he does is the president's got to go. He's been tainted; he can't stay... So he forces him to resign without a clue as to what he's going to do to replace him.

So long story short, I get invited by an intermediary who I've known for years who's close to Corzine to go down to meet with him. I thought I was going to be asked to sort of do like a consulting thing, like a turnaround thing. But a half an hour into the conversation he asks me if I'm willing to be the president of the university. And at least I had the good sense to say, "Well, first of all I have to think about it. Second, I wouldn't agree to be the permanent president of the university, but I'll be the interim president of the university." Because you need someone to come and clean it up and get people pissed off. And besides, the president of the university eventually should be a distinguished biomedical scientist and clinician and I'm not, so he said fine. So anyway, I said I have financial complications with my current employer; I have to work out a leave of absence and all of that kind of stuff. Anyway, I eventually ended up doing it. And I got there in March of 20 --

Berkowitz:

Where was the headquarters?

Vladeck:

Newark. March of 2006 and pretty soon we were into budget stuff, and all of the people around the governor who would you know, had been my big friends and supporters and so on and so forth, every time I needed anything, they would be very friendly and responsive and nothing would happen. Then -- anyway, the denouement was the monitor, who was this asshole by the name of Herbert Stern, who was a former federal judge and big Republican New Jersey Politician, wanted me out of there as soon as possible. And so well before any rational person would've done, he demanded that they begin the search for the new permanent president, which they did.

And then a bunch of people around the university said, "Are you going to receive the permanent job?" And I said no. A bunch of people around the university asked me if I would throw my hat in the ring and I said "No, [unintelligible] really would," and we were halfway down the road doing a bunch of things. So I said, "Okay," at which point Christie undertook to smear me, and he had the monitor issue a report accusing me of all kinds of things that were not true.

And then the big denouement was when the board chairman got a deal with the rest of the board to conduct an independent investigation by two -- he got two former State Supreme Court justices to agree to do it -- into the allegations about me. The signal came back from Christie as, "If you do that, I'll really go after you, because how can you question the monitor like that?" So -- and the question was would Corzine fight it or not? And I went to

meet with him in his Newark office and the short answer was no. He did not have my back at all, so I left.

Vladeck:

I mean, they found the new guy and the day the new guy arrived I left.

Berkowitz:

That was your second involvement with New Jersey stuff.

Vladeck:

The second involvement -- much the less happy -- I had the best time in New Jersey health department back in '79 through '82, but it was a different world. The state political world was entirely different. It was just a totally different world.

Berkowitz:

So did you get to go back to Ernst & Young, or --

Vladeck:

I got out with my life and I went back to Ernst & Young for a while, and then my friends with the Greater New York Hospital Association in 2009 called me and asked if I could do some work for them on health care reform.

Berkowitz:

Are these the people you had worked for before?

Vladeck:

No, I'd worked for the United Hospital Fund of New York, which is a very different organization, but I've known these guys all my life, all my professional life. So one thing led to another, so finally we worked out a deal in which basically, I could do my own consulting projects about two-thirds of the time and do association-related stuff the other third, and it was a lot more comfortable than Ernst & Young. So I did it, and that's where I've been.

Berkowitz:

I see. That's a good story. Part of that could be a West Wing Episode. That stuff about the report of the Medicare Commission. That would make a wonderful --

Vladeck:

Oh yeah, that was a good story.

Berkowitz:

So now let me ask you one last kind of series of questions here, and that is that we want to kind of get at this business of having been the CMS head or the HCFA head. Is this something that continues in a sense? Do you feel like you're part of a club? In other words when somebody else going to get this job do you say "Well, let me tell you about what's going to happen"?

Vladeck:

I do feel enormous empathy with people in the job. And I have, with some of them, I guess especially Scully and then Berwick. They would call me and say -- Nancy-Ann did too, but Nancy-Ann mostly -- "Did you really say that?" or "Did you really promise that, or what are we supposed to do about this?"

Berkowitz:

She knew you pretty well, right?

Vladeck:

Yes. It's interesting, it's a bit digressive, but people ask me what was my most impressive accomplishment or my proudest accomplishment. I said my proudest accomplishment at HCFA was something that won't even occur to most people that haven't been inside the government, I said the only time in the history of the agency and one of the few times in the history of senior jobs in the executive branch at all, we had a seamless transition. We worked out a real honest to goodness succession plan.

And at the beginning of 2007, right after the '96 elections, after Nancy-Ann finally gave into Shalala's begging and pleading, she agreed to come over to the agency as deputy administrator in the spring of 2007 and then when I left, which we had raised for the time window later in the year, she would automatically be acting. She wouldn't have to wait for confirmation hearings or anything and she could be acting until she got confirmed. And it turned out that was very fortuitous because I dumped the entire implementation of the Balanced Budget Act in to her lap. [laughs] But she still speaks to me. And by you know, I left on the 13th of September and as of the 14th, she was acting, so it went very well.

Berkowitz:

Left the continuity there.

Vladeck:

So we kept the continuity.

Berkowitz:

Not like with Gail Wilensky?

Vladeck:

Gail, I never had that -- yeah, I never had that kind of relationship with Gail. Of course, she preceded me. Tom and I talked a bunch. Don and I talked a fair amount. Of course he wasn't there that long. I tried to talk him out of taking the job. I still wish he would've listened to me.

Berkowitz:

He would be governor today.

Vladeck:

Yet another one of my professional friends into whose hopeless political campaign I contributed money, but even with Marilyn, who I didn't know before she took the job, I've talked to a number of times. I will call her about something that particularly concerns me or bothers me or whatever and she's been very responsive, but she hasn't sort of reached

out. But I totally empathize with people in that role or in similar roles. The world looks different when you're there. What you have control over and what you don't have control over is different.

Berkowitz:

A lot of the people were the same too, right? You could say this guy on the ways and means committee, this staff guy --

Vladeck:

Yeah. I would say if you look at below the level of political appointees, if you look at the 12 or 15 most senior career people in the agency, half of them are people I worked with 15 years ago. Some of them I still remain in very close touch with.

Berkowitz:

That's good. That's a good memorial.

Vladeck:

And boy, I feel for them. You know, it's gotten -- it was hard then; it's gotten harder.

Berkowitz:

Since the Affordable Care Act, or just in general?

Vladeck:

No, just the continued evaporation of civility from public policy...

Berkowitz:

Even from the Clinton days.

Vladeck:

Well you know, the '94 election was a big turning point in that regard. I mean I kind of grew up in this business. I mean, one of my first big steps forward in the professional world was in '83 or '84, I got invited to what was then the annual Ways and Means Committee retreat, which was a bipartisan thing conducted over the Washington's birthday recess every year. And they rotate topics of Ways and Means, so one year they do trade, one year they do taxes and eighty-whatever year it was, they did Medicare. They invited me as an outside expert, and every member of the committee and all the committee staff from both parties attended. And we all flew -- that year the retreat was in Jacksonville, or in Ponte Vedra, Florida. It was always somewhere -- until "60 Minutes" exposed it -- was where Rostenkowski (D-Illinois) could play golf.

Berkowitz:

He charged for his golf clubs one time, too.

Vladeck:

We all flew down together on Air Force congressional transport and hung out together. And on the flight down, Rostenkowski and Bill Frenzel who was the ranking Republican at the time, played cards with each other. I mean that's the way -- and, you know, there were some very sharp disagreements, but --

Berkowitz:

It was a much more permanent institution.

Vladeck:

But the mores of the institution were, you got along, and that has eroded sort of gradually. The big change was -- really, the Ways and Means Committee was actually one of the last holdouts in the polarization of Congress, because it'd always sort of seen itself as above everybody else in a whole variety of ways. The committee's staff, I mean, there were Democrats and Republicans on there, but they were committee staff so they were so on and so forth. And Gingrich blew that all up very willfully and consciously when he became Speaker.

Berkowitz:

So that after 1995, the policy environment's different.

Vladeck:

It's a lot different. Yeah.

Berkowitz:

Good. That's a good note on which to end.

Vladeck:

Okay.

Berkowitz:

Thank you.

Vladeck:

My pleasure. Glad to do it.

Interview with Kerry Weems

By telephone on May 27, 2015

Interviewed by Edward Berkowitz

Transcript edited for clarity.

Berkowitz:

Today is May 27th, 2015, and I'm talking by telephone with Kerry Weems. I'm in Baltimore and Mr. Weems, you are in California? Is that right?

Weems:

That's where my office is.

Berkowitz:

I want to ask you about your life a bit and I also want to talk to you about your time at CMS as well. So maybe we could just start at the beginning. I know you grew up in New Mexico and you spent time in your childhood in Las Cruces. And then you went to college there, too, at New Mexico State, I believe. So I have all that right?

Weems:

Yes, that's correct.

Berkowitz:

And could you talk a little bit about your interests at that time? I know you majored partly in philosophy in addition to business. I was just curious about that. What was the attraction to that?

Weems:

Well, I did grow up in Las Cruces, New Mexico. I moved there at a very young age and went through public schools there.

The thing that's probably different in the narrative is in my junior high and high school years, my family went overseas to Saudi Arabia. My father worked for a defense contractor. And so I was given the opportunity to see a lot of the world -- not just southern New Mexico at that point. Because of the nature of the American community in Saudi Arabia at the time, there wasn't a school system, past the eighth grade, so I came back to the United States for schooling and went to school in Texas.

My father also completed his tour in Saudi Arabia, having returned to Southern New Mexico, I went to New Mexico State University. I got two degrees, a BBA in business, as you noted, and also a BA in philosophy. The philosophy degree just came from a very strong interest in the ability to read through a lot of the great works of Western civilization to become a much more disciplined writer and much more disciplined thinker. And the degree succeeded in that way. The BBA was to help with the eating thing. As I suspected

when I graduated with a degree in philosophy, none of the philosophy companies were hiring at the time.

Berkowitz:

[laughs]

Weems:

So those two things put together have served me very well. Now, I also went on to get an MBA at the University of New Mexico in Albuquerque and completed that degree in 1981. So I had a pretty good background in writing and in reasoning. And then I got an MBA and that's, in many ways, what prepared me for what turned out to be a fairly long federal career.

Berkowitz:

I see. Did you have any carryover from being in Saudi Arabia? Did you know Arabic, or have an interest in Muslim culture or something like that?

Weems:

I certainly had an appreciation for the culture and Islam. I had a street fluency in Arabic and actually had the opportunity to go back to Saudi Arabia a couple of years ago and much of the Arabic came rushing back to me, though Saudi Arabia's a much, much different country today than it was in 1968.

Berkowitz:

So you spent this time in Saudi Arabia, an exotic place, and in New Mexico, where you grew up, and eventually you went to Washington, D.C., as I understand it. How did that come about?

Weems:

Just as I was completing my degree, the Republicans won the Senate. As you know, they took the Senate in the November 1980 elections.

Berkowitz:

The Reagan elections.

Weems:

They were organizing themselves and a senator whose acquaintance I had made and assisted along the way brought me to Washington as a legislative assistant when I completed my degree. That that was Jack Schmitt -- Harrison Schmitt -- the astronaut. And he was, as you may recall, promptly defeated by Jeff Bingaman about a year and a half after I got to Washington.

Berkowitz:

I see. Did Senator Schmitt have a special interest in NASA?

Weems:

He did. He sat on the committees that had oversight for it and also funding. He maintained that interest and, as I understand it, still does and continues to press for a rational, forward-looking space policy for the United States.

Berkowitz:

Interesting. So it looks to me like you never really went back to New Mexico --

Weems:

No.

Berkowitz:

But rather you stayed in Washington. What was behind that decision?

Weems:

Well, like many people, you come to Washington for two years and you look back and it's 30 years later. That was my experience. Once Senator Schmitt was defeated, I really was at inflection point of whether I returned back to New Mexico or went someplace else or stayed in the Washington area. I decided to stay. I thought that there was still more that I could learn and more that I could do and experience in government. So I took a job in the career civil service, low man on the totem pole. I was a junior budget analyst with the Social Security Administration.

Berkowitz:

Working in Baltimore?

Weems:

Working in Baltimore. I commuted for two years before taking another job with SSA in the Washington, D.C. area.

Berkowitz:

I see. So when you joined the civil service, did you have to take an examination?

Weems:

No. Because I had been a government employee in the Senate, no examination was required. They looked at my work history and matched it to an existing job.

Berkowitz:

So you worked at SSA starting about 1983 or so and that was a time when the agency itself was concerned with the disability crisis. They had been removing people from the SSDI roles for not meeting the terms of disability. And that became a major concern in 1983, 1984. Is that something you were aware of?

Weems:

Absolutely. During the time I worked for Senator Schmitt, I moved to being a professional staff member under his sponsorship on the Senate Appropriations Committee. The controversy about the disability reconsiderations and CDRs, Continuing Disability Reviews, -- that controversy had certainly risen to our attention at that point. By the time I joined the

agency, I would say that it was fairly embroiled in it. I was a budget analyst, primarily working on the SSI program, the Title XVI program.

Berkowitz:

Working in the budget office at SSA, does that mean that you work primarily inside SSA or do you work with OMB? What's the nature of that work?

Weems:

The budget process within the federal government is a very, very structured -- not to say hide-bound process. And at least to my knowledge remains virtually unchanged from that point even to now. So, depending on the time of the year, the agency formulates a budget inside of the agency. At that point, Social Security was not an independent agency. It instead was under HHS. And so it formulates its own budget, sends it to the department. The department makes whatever changes they believe necessary and the department sends its budget to OMB and then OMB makes its decisions, typically on the Wednesday before Thanksgiving. Then agency appeals occur that following week, and they hope to settle them in a couple of weeks when the president's budget is put together.

My role was very hands-on at the beginning in terms of formulating the budget inside of SSA; then I had sort of a diminishing grasp as it went through the process and was finally sent back. Once it comes back, once final decisions are being made -- much of the process is just documenting what the numbers mean and what the expectations are around those numbers.

Berkowitz:

Did you consider yourself as someone with good quantitative skills?

Weems:

Yes. And with good writing skills.

Berkowitz:

That's a good combination to have.

So without meaning to get too far into the weeds about this -- I'm just curious about this budget question at SSA. It's running a big entitlement program -- several big entitlement programs. But yet you still have to have a budget for the administrative costs, for running the agency, and that has to go through the regular budget review process. Is that right?

Weems:

Yes, that's correct. It's also largely true with HCFA at that point and then CMS later. The actuaries produce a forecast for the entitlement programs. And really, that's the way to look at them. They're a forecast. For the most part, unless there's some policy decision being applied, the OMB (Office of Management and Budget) and the Department left them alone. They couldn't claim to be smarter than the actuaries.

Now, if there were, for instance, new policies to be applied -- legislative changes or regulatory changes -- those would be laid over the actuary's estimates and usually the actuaries would make the estimates for the effect of either legislation or regulation. And

those would become part of the budget. But the baseline budget, the budget that the actuaries produced was always at the baseline current law budget. It was always evident; you could see the changes that were made to current law and regulation. Now, the thing that the agencies spent a tremendous amount of time on was defending their own administrative budgets.

Berkowitz:
[affirmative]

Weems:

So we have these massive entitlement programs. What are the resources that we're going to apply to run them? That account is called Social Security's Limitation on Administrative Expenses. Because Social Security administers a number of trust funds: DI (disability insurance), old age and survivors trust fund, and also some Part A, some Part B in Medicare, and then has some general funds responsibilities. Their administrative budget is taken from all of those trust funds. But the appropriation itself is a limitation on what it can take from those funds. And so Social Security had to scrap very hard every year for its budget. A lot of that has to do with the way that Social Security decided at that time -- and Congress and everybody else -- to do its work. That way was to have a massive field structure. It was something like 1,200-1,300 field offices at the time.

Berkowitz:

Right; that is a big difference from HCFA or CMS operations.

Weems:

Sure. In fact, that difference continues today. Social Security and CMS administer roughly the same dollar value in terms of their entitlements -- at least the same order of magnitude. Social Security does it with 70-75,000 people and CMS does it with 6,500.

It's a big difference, but a lot of that goes to some of the fundamental decisions made when Medicare was formed. Using contractors as the animating force has always been true in CMS; using civil servants as the animating force for Social Security has always been true. There are two very different traditions in the way that they face the public.

Berkowitz:

Right. I haven't thought about this before, but in 1965 since Medicare would become a new bureau at SSA rather than a new department or a new agency, it made sense to use the existing structure of SSA to run Medicare. That continues, because if you apply for Medicare, you apply to an SSA person or office. Isn't that right?

Weems:

That's correct. And that is why still some of the Social Security administrative dollars are taken from the A and B trust funds.

Berkowitz:

Interesting. At some point you went from working at SSA and you went over to the broader Department of Health and Human Services. And it seems like budgeting, now, was your specialty?

Weems:

Yes. That's correct. A promotion opportunity presented itself and so I moved over to the Department and worked on the Social Security accounts from the Department's perspective.

Berkowitz:

Was that a different point of view?

Weems:

Working in the Department really puts individual budgets within a broader context. You still worked very hard to achieve the goals of the particular agency, but at the same time, you viewed your work in a much larger context because you knew how the Social Security account was going to fit into the larger goals of the Department. So it was a change in perspective.

Berkowitz:

I see. You talked about the fact that NIH (National Institutes of Health) and the CDC (Centers for Disease Control) have political followings and are attractive politically. But lack of that makes it more difficult for HCFA/CMS to carry out its work. Were you aware of that at the time? Did you have a sense of where HCFA was in the bureaucracy?

Weems:

Yes. I would say that the appeal of the National Institutes of Health and the Centers for Disease Control and then other selected programs -- for instance, Head Start -- all of those have bipartisan, very popular political backing for a number of reasons. You know, the NIH holds the promise of a longer, healthier life. And at the same time, we shouldn't forget the thing that also happens there: those dollars go to universities that are in Congressional districts.

Berkowitz:

Right.

Weems:

The CDC has been very successful in transforming itself from its roots as a disease detective to really a grant-making organization to state health departments. The state health departments are very, very dependent on funds from CDC. So while the CDC stands as an emblem of vigilance and protection in the United States, the states now are a very, very substantial extension of the CDC in a real sense and also in a financial sense.

Berkowitz:

But the CMS does have perhaps the advantage of contracting so much out. There must be people who want those contracts.

Weems:

There are, but for the most part until recently, those contracts for bill processing didn't turn over all that much.

The original Medicare law required -- if I can get this right -- the Part A contractors to be provider-nominated, meaning the local providers --

Berkowitz:

Right. The hospitals could choose whom they wanted to deal with, basically.

Weems:

Correct. And for Part B, the contractors had to be an insurance company of some sort. Now, that's been changed and also the number of contractors has changed.

I think at one point, there were well over 100 contractors who were processing Part A and Part B claims using a variety of systems.

Berkowitz:

Right, and deliberately so. They were spread out all over the country and various interests represented.

Weems:

Right. But those interests are much more diffuse than the national interest of a war on cancer or improving early childhood education, in the case of Head Start. Or the national interest in providing access to healthcare through community health centers.

Berkowitz:

Perhaps you could talk just a bit more about your HHS career. I know that at one point, you were what's called, I think, a "Chief Financial Officer." Maybe you could talk about that, how you got to be that, and what that does.

Weems:

First of all, my entire federal career, the 28 years' worth, was very rewarding. I can't see a circumstance under which I would go back, but I don't regret an instant of it. I just found it to be really, really great.

The principle responsibility of being the Chief Financial Officer is completing an annual audit. HHS is audited every year. It's an independent audit. The inspector general's office actually chooses the auditor. And really much of the job is consumed with getting through the audit and getting through a clean audit.

In addition, the job involves establishing clear financial controls in the agency, making sure that the agency finance system works within the boundaries provided by statute and guidance from OMB, and -- during my tenure there -- working with a team of very talented employees we also successfully implemented a department-wide financial management system. It was using Oracle Federal Financials. Almost no other department has succeeded in doing that. We were able to do so on budget, in scope, and on schedule. That was a significant accomplishment of some very dedicated financial professionals in HHS.

Berkowitz:

So does that mean that the guy in ASPE (Office of the Assistant Secretary for Planning and Evaluation) now has an easier time handling his budget requests and following his budget as the year goes on because of your system?

Weems:

It doesn't particularly help -- or didn't at the time -- with budgeting, but it did help a lot with financial management and financial controls.

Berkowitz:

I see. So now you got to be, toward the end of your tenure at HHS, the Deputy Chief of Staff for Secretary Michael Leavitt between, I think, 2005 and 2009. That's a fairly visible position, I would think. How did that come about?

Weems:

By the graciousness and generosity of Secretary Leavitt, is the short answer. The longer answer is that Secretary -- at that point, Administrator Leavitt -- he was at the EPA -- was nominated to become the HHS Secretary. He knew that he was going to face confirmation to run a very large, very complex organization. And he asked me to -- I was the person left standing, at least on the budget and department operations side -- to conduct those briefings. So we briefed him up. I spent a lot of time with him personally to prepare him for a couple of confirmation hearings, which could have been fairly contentious, but weren't. They were good hearings. And then, once he was confirmed, he asked me to change my role. At that point, I was the Principal Deputy Assistant Secretary in the budget office. He asked me to come up and be his Deputy Chief of Staff. I remained a career employee and this was a non-political position. It was just to help him run the Department with somebody who had been around and whose candor he trusted.

Berkowitz:

Was there a Western connection with Secretary Leavitt?

Weems:

Not really. By that point, I had become pretty much a creature of the mysterious East.

Berkowitz:

[laughs] Okay. So let's talk about the next phase of your career where you eventually are nominated to be a CMS Administrator in about May of 2007. It seems as whereas budgeting was your specialty -- developed over time -- somehow health is also becoming a specialty. So I wonder if you could talk about both of those things: getting nominated for the CMS job, as -- I believe -- still a civil servant, and health as an interest?

Weems:

I really think what they were looking for at the time if you consider that moment in time in 2007 --

Berkowitz:

Right, late, late Bush 43.

Weems:

It's at the end of the Bush administration. The Congress is completely in the hands of the opposing party. There are vacancies that need to be filled, but there wasn't a particular ambition on the part of the administration, at that point, for any further legislation -- in the Medicare, Medicaid world.

Berkowitz:

And they already had the legacy of the Medicare Modernization Act.

Weems:

That was already in place and Part D, the prescription drug benefit, was stabilizing. It was not fully stable at that point, but was stabilizing.

I think what you looked for at that point isn't necessarily someone with particular health acumen, but rather managerial skills. It's my belief that I was chosen for that job because of the management and leadership that I had shown in previous capacities, certainly not for budgeting. When you're at the head of CMS, budget consumes very little of your time.

Berkowitz:

And just to be clear on this -- and you're still a civil servant?

Weems:

I was.

Berkowitz:

I'm surprised that the Administration -- with a chance to get somebody to whom they have political debts into a visible job -- picked a civil servant.

Weems:

Well, sure. Let me agree with that. Frankly, getting my name through the White House, while I don't have particularly deep insight into that, probably wasn't the easiest thing in the world. But at the same time, who's going to stand a better chance for confirmation? If indeed they have political debts to pay, that's going to become apparent. In the confirmation process, the Senate can exercise whatever leverage it can. But as a career civil servant, it's pretty difficult.

Berkowitz:

I have this picture of you sitting down with lots of briefing books before you go to talk to the Senate committee and go through confirmation hearings. What is that process like?

Weems:

I've been on both sides of that table for many years. Well, one side of the table for many years and then briefly on the other. What you try and do and what I tried to do is to prepare the individual and then prepare myself for the hot button issues: what am I -- as a matter of politics -- going to have to defend and how can I defend it. Those questions will always happen. And then, how can I, thematically, rather than in particular, absorb enough of the agency so that I seem fluent with the issues facing the agency? I want to show that I may not have all of the answers yet, but am able to demonstrate that fluency and

confidence that might give the Senators confidence to be able to consent to my appointment.

Berkowitz:

Did you also get information about this is so-and-so, he's on the Senate Committee on Finance; he's long been interested in X, Y, and Z?

Weems:

Sure. You always do particular member interests. Those are kind of at the end. And many of the member interests evidence themselves in the individual meetings that you have in advance of a hearing. They are called "courtesy calls" and Senators will either make time for you or they won't. For the most part, I found the courtesy calls extraordinarily helpful. Not just in introducing myself to the Senators and to the Senate at large, but, in fact, it formed the basis for a relationship that was going to be needed throughout my tenure.

Berkowitz:

I see. So you did actually have a confirmation hearing on July 2007. And then some sort of political process seems to have intervened, having to do with SCHIP?

Weems:

Yes.

Berkowitz:

What's your sense of that, looking back on it?

Weems:

When the Senate adjourned in July 2007 several days after my confirmation hearing, they did confirm some individuals and some with HHS, but not me. My guess is there was some horse-trading involved there and if so, they made absolutely the right decision and I stand behind it 100 percent. The individuals that got confirmed would not have been able to serve in those capacities without confirmation. I, on the other hand, was able to without the consent of the Senate.

The thing that really made it impossible for me to be confirmed was an SCHIP letter that came out during the recess of the Senate in August 2007. That letter came from CMS and really had to do with eligibility for reimbursement for SCHIP programs and how participation would be counted. There were a number of Senators -- no reason to recount the history -- who just really believed that to be a very, very hostile act. And there was no way that they were going to act in a way that seemed to give their consent to that. And my confirmation would have done that.

Berkowitz:

So that it becomes a matter of vote on SCHIP, which the Democrats want to expand and the Administration wants to contain?

Weems:

Yes. I perfectly understand that. They did not want to give the appearance of consent. Many of the people who were opposed to my confirmation for that reason were very, very gracious to me otherwise. I had good relations with them.

Berkowitz:

I see. Here's a question I wanted to ask you that -- I hope it's not inappropriate. That is that I read somewhere that you are six feet, six inches tall. Is that correct?

Weems:

That is correct.

Berkowitz:

That's another perspective that you have on life that the rest of us don't have in some ways. Do you think being so tall helped you in your career?

Weems:

One never knows, but certainly it helped people remember who you are, for good or for ill. There's a fairly substantial body of research that says that in general tall people have a tendency to be more successful. I'm not sure whether it was so in my particular case.

Let me also add that even at that height, as a government employee, you still fly coach.

Berkowitz:

[laughs] So I guess there are disadvantages, too, to height.

You served as Acting Administrator September 2007 through January 2009, which was the end of the Bush administration. That was a decision, too, wasn't it? There was a decision at that point to actually go ahead with that Acting Administrator appointment. Was that a complicated decision?

Weems:

No, not at all. In fact I think that there was even some interest in appointing me to that position in August of 2007. But I wanted to wait until the Senate returned before that appointment was made because one of the agreements that were made for the recess of the Senate was that there would be no recess appointments. I didn't want this to look like a recess appointment because that certainly could have significantly tainted my tenure.

Berkowitz:

Do you think that, in this whole process, the fact that you were a civil servant maybe helped?

Weems:

It helped. It also meant that the Republicans, who could have been helpful in a confirmation process weren't politically beholden to me in the way that might have been with other candidates. I didn't represent a political symbol to either side.

Berkowitz:

So when you were at CMS you dealt with a lot of things because the agency does a lot of things. I wanted to ask you about one in particular, and that is nursing homes, which seem to have been a priority of your time as Administrator. I know that you helped to put in place the five-star nursing home rating system, where nursing homes are rated and a five is the best. Is there a story behind that?

Weems:

Well, actually there is. It was in a Congressional hearing that I had -- it would have been in 2007 -- it wasn't long after I was there. I forget the actual substance of the hearing, but Senator (Ron) Wyden, (Democrat) from Oregon, began a dialogue with me in the hearing. He talked about the inability for a consumer to choose a nursing home based on any objective standard of quality. Well, that's not completely true. You had to know how to read an inspection report. You had to know a lot. There really wasn't a consumer-friendly way of comparing nursing homes. And as I recall, Senator Wyden said, "It's easier for a consumer to choose a washing machine than to choose a nursing home." A thought that passed through my head at that moment was, "He's exactly right. And we should do something about that." That was the moment that gave birth to that whole initiative. It was difficult. We didn't want to work with the trade associations. We brought the Congress in on an informal basis. We did a very large consultative thing. We were finally able to bring it to fruition about a year after that hearing.

Now it has been -- at least through press reports -- very successful. They're continuing to add to it to make it a more finely tuned tool than it was. I'm glad of that.

Berkowitz:

Everybody has anecdotal information, as I'm sure you've realized, in going through this process, from their own family or from whatever. It seems to me that if I were doing this, I would have a measure. And that would be that if you walk into a nursing home and all the bells are going off at the nursing station and no one seems to respond to them, that might be a sign that something's wrong. Did you ever think about that kind of thing at that level?

Weems:

Well, actually, as part of this I went on a couple of nursing home inspections. The government, in doing this, has to rely on some fairly objective standards.

It is true that an inspection team goes in and if there is a cacophony of alarms, and nobody seemed to be paying attention to it -- they would probably write it up as an immediate jeopardy and have the institution do something about it right then. We always said look at the report, but nothing, nothing beats a visit.

Always visit ahead of time. There are things that are clear signals: the attitude of the staff, for example. Thinking of the thing that you refer to with the alarms going off, does staff have alarm fatigue? Alarm fatigue is a real problem. How does the place look? How does it smell? Those kinds of things are also indicators but not something that the government can provide directly to the consumer.

Berkowitz:

I see. So that's one initiative that you had. And you also seemed to have developed an interest in electronic medical records. Is that something else that became a priority for you?

Weems:

Yes; that was a holdover from my previous work in budget. It was a particular interest of Secretary Thompson's. He came into office with that interest. He worked to create the Office of the National Coordinator (National Health Information Technology Coordinator). That was actually a fairly arduous process to get the executive order that created the ONC, and then to bring in Dr. David Brailer as the first National Coordinator.

I'd learned a lot about electronic records -- probably not enough -- but I learned a lot about them during the time that I was helping with the executive order and helping Dr. Brailer get settled. And then we also had to do a pretty significant set of budget gymnastics just to save funding for the National Coordinator when it was in a very nascent state. We had to work with the Congress to rearrange some funding and as I recall the National Coordinator's office wasn't in our budget at the time. So it did require, as I said, some budget gymnastics.

My interest carried over into CMS because that is, frankly, the big stick in terms of being able to either incentivize electronic health records or to provide some sort of certification of compliance. I note that even in today's *New York Times*, there's a piece about how the Administration made a very significant investment early on in electronic health records and still a number of the commercial entities resist sharing information. Now, we could see that at the time as a problem and I'm sure the current Administration saw that from the beginning, as well. But those problems will persist for a while. I do think we'll get to interoperability sometime in the future.

Berkowitz:

I'm an academic but I work in a bureaucracy, like everyone does, and we just got a new piece of software this year, which is used to file our annual reports, which are required of us. No one in my department knew how to use that software and there was incredible negative reaction. I was wondering if that component of electronic records has ever been thought about -- the people that are confronted with this, "Yes, you must enter all this data now." Their first reaction might be fear.

Weems:

Well, certainly resistance, and completely understandable resistance. It's not easy and it's something that is a definite change to a work process.

And this has come during the time when physician practices have been consolidating. For a solo practitioner being confronted with this, it is overwhelming. When you have group practices, the investment in time, effort and training really takes away from your ability to practice medicine. The setup cost and the learning cost are significant in adoption.

Berkowitz:

So you think maybe I'll learn how to do my annual report in time?

Weems:

Well, there is also such thing as bad software too.

[laughter]

Weems:

There is software that is not user-friendly, not intuitive, so that no matter how much training you have, you might still hate it.

Berkowitz:

So presumably, when we pick national software standards for these medical records, we'll keep that in mind.

Weems:

Yes. This administration and previous administrations have all worked toward standards. The meaningful use standards that are embodied in the regulations that the Administration has put up have gone a long way down that road. The fact that we're not at the end of that road may disappoint some people, but, frankly, looking back over the progress we've made, I'd take great hope from it.

Berkowitz:

Let me ask you about something else that you said a little bit earlier. You talked about the carriers and other people that are contracted to review and pay claims on Medicare. And you said that there were a whole bunch of them, which there were at first. But it seems to me that the trend now is to greatly reduce the number of those contractors and consolidate the operation a little bit more. Is that something that you were aware of?

Weems:

Oh yes. Contractor consolidation was something that probably began even before my tenure at HHS. The significant amounts of consolidation into the MACs (Medicare Administrative Contractors) occurred when Mark McClellan was Administrator and I was running the HHS budget. We worked very closely together to try and achieve that particular goal. The goal was to reduce the administrative burden of having to manage so many contractors and also to standardize on a particular system. At the outset, there were as many systems as there were contractors.

We consolidated down to standard systems with a proliferation of contractors. And then consolidated down to a few contractors with very few systems and very few configurations that were different from the norm. The goal is that a claim filed in New Hampshire is processed and paid in the same way that a claim filed in Oregon is.

Berkowitz:

Right, so we have more of a national Medicare system, rather than what some people said was a series of local systems.

Talking about Medicare, I read somewhere that you said that with Medicare, we buy by the yard. My question is, how should you pay for Medicare? And how does CMS go about implementing that?

Weems:

I said we buy Medicare services by the yard and we shouldn't. During my tenure at HHS and also at CMS, we were making the transition from being an indemnity-based insurer to trying to pay for value or pay for quality. And it had been a slow march but with continuing progress with the value-based purchasing system for hospitals with PQRI (Physician Quality Reporting Initiative), now PQRS (Physician Quality Reporting System).

With some of the other value-based payment systems, CMS is not quite yet paying for an outcome, but getting closer and closer to that. In the end, that's what I believe Medicare should be doing, is paying for quality, paying for outcomes, not just buying services by the yard.

Berkowitz:

So then the question becomes how do we do that? I know there are a lot of different opinions on that issue.

We've just come through this debate about the Affordable Care Act and the implementation of the Affordable Care Act. As I understand it, you were a critic of a public option in the Affordable Care Act under the theory that Medicare's such a permissive system -- any doctor can be a member of it. Therefore, it's hard to organize some sort of public option. Is that correct?

Weems:

It is. That was documented in April 2009 Wall Street Journal editorial that Ben Sasse -- now Senator Sasse (R-Nebraska) -- and I wrote. It really was opposition to a single-payer system because of my experience with Medicare. The insurers who have a profit incentive are much better at forming networks. They're much better at finding fraud. They're much better at judging the quality of their physicians than Medicare is. And so a public option just seemed particularly inefficient as opposed to where they landed, and that is allowing insurance companies to be the intermediary.

Berkowitz:

I see. I have just two more questions for you, if I might. After your time at CMS, which seems to have had an effect on you in terms of your interests -- it seems that you've concentrated on healthcare. Is that true?

Weems:

It is. I gained what I would call credible expertise in that area. I also have expertise in the budgeting area, but the budgeting arena doesn't really translate into the non-governmental world as well as some acumen in the health world does.

Berkowitz:

And that's where you are now -- in the private world?

Weems:

That's right.

Berkowitz:

So, last question -- If someone says to you, "What is the future of Medicaid and Medicare?" what do you tell them?

Weems:

I'll respond to Medicare first. I think Medicare will become a progressively better payer and will be used as an engine to practice better medicine in the country. I think that the things that the agency learned in the '80s, '90s and aughts about being able to use the payment system to drive quality -- I see that accelerating. It's one of those things that transcend party politics. It does not transcend pressure group politics, but to me, that's merely a matter of pace, not a matter of whether.

Medicaid will have to undergo some sort of transformation. Part of that transformation, you can see now, is in managed care. But Medicaid is putting substantial stress on state budgets. It is beginning to crowd out other state priorities, like higher education and transportation and, in some cases, public safety. Medicaid is going to have to become a much more efficient provider than it is today. And some of that may have to do with the formula by which Medicaid is determined. One of the things that really hasn't been looked at from the financial sense is the risk groups inside of Medicaid and how that formula should work for them.

The so-called "well moms" and kids are not particularly expensive especially when compared to the profoundly ill, and those needing long-term care. In the end, there's going to have to be some sort of, I don't know, grand bargain, if you will, between the federal government and the states about how they're going to handle that. Otherwise, in some states, Medicaid costs will completely crowd out some of the other priorities.

That pathway is not quite clear to me; at least the end point, if there is one, isn't so clear. But the necessity to do so occurs in state legislatures around the country.

Berkowitz:

And it's complicated by the fact that the Medicaid program in New Mexico might be different from the one in Massachusetts.

Weems:

Yes, there is not just one Medicaid program; all of them are different in the states and territories.

Berkowitz:

Right. Thank you so much for doing this interview. We really appreciate it.

Weems:

I hope it was helpful.

Berkowitz:

It was definitely helpful. Thank you.

Interview with Gail Wilensky

Bethesda, MD on April 27, 2015

Interviewed by Edward Berkowitz

Transcript edited for clarity.

Berkowitz:

Today is April 27th and we are in the Headquarters of Project HOPE in downtown Bethesda. I'm talking with Gail Wilensky. We talked in 1996 (for the 30th anniversary of Medicare and Medicaid project), as part of a series of interviews we did with every HCFA/CMS administrator up until then. That last time we talked mostly about HCFA and about how you came to use economic analysis to inform healthcare.

The interview today is part of a follow-up series of interviews we're doing on the 50th anniversary of Medicare and Medicaid. I'd like to give you a chance to talk about some of the subsequent events in healthcare policy. After you were the HCFA administrator, you went to work in the White House. Is that correct?

Wilensky:

Yes, I was the senior advisor to the President on health and welfare issues. My formal title was Deputy Assistant to the President for Policy Development, but I was the senior person in my substantive areas. During the period from March of 1992 through the end of the year, whenever the President would speak about these issues or travel to do an event involving these issues, I would brief him and travel with him. That was a very interesting experience to have, although frankly, running the agency was my preferred experience because that's really your shop whereas when you're in the White House, you're staff. Although, if you're going to be staff, being staff to the President is probably as good as it gets.

Berkowitz:

Right; I see that. You must have had a chance to actually interact with him personally then?

Wilensky:

I did and that was not something that I did very often when I was running Medicare and Medicaid. I occasionally was in a large meeting where he would be present, but I had minimal direct interaction with the President when I was at HCFA. I had a fair amount of interaction over the years with, John Sununu, his chief of staff and with Dick Darman who at the time was the head of OMB. Darman, who took the lead on healthcare reform development, thought highly of my skills as an economist and my expertise in the financing of health care, that I was knowledgeable, smart, understood both the politics and the policy involved in healthcare issues. He frequently turned to me when he wanted somebody from the department.

During the last year, when I was staff at the White House, I had much more contact with the president and had opportunities to enjoy some of the perks of being White House staff

like traveling on Air Force 1 or Marine 2 -- the other helicopter that goes with the President -- sitting in the President's box in the Kennedy Center, or playing tennis on the White House tennis courts. That's what you get in exchange for working seven days a week and very long hours. Not a lot of money, some perks but the very heady experience to be able to have an opportunity to have even more direct influence on the policy leadership.

Berkowitz:

What's it like to do that in a campaign time? Are there two separate staffs for a lot of things?

Wilensky:

There are different staffs. The election campaign staff is separate. It is very important to keep it separate from those who are on the White House staff; making sure you understand the rules of the road on what you can and cannot do as a member of the White House staff versus an outside campaign person becomes important.

The limitations weren't particularly onerous for somebody like me. I really regarded my input as important in the policy area. I think over time I have become much more politically savvy than I was up until the late 1980s when this started, but I didn't regard myself as there to be a political advisor as much to be a thoughtful policy advisor who was a market-oriented economist.

Berkowitz:

I have to ask you one more question about the president. He is famously known as a good person and people speak very highly of him regardless of political affiliation. Is that true?

Wilensky:

Yes. He was a very good person. He was not only an exceedingly nice and kind individual; he surprised me because he was a self-deprecating, unassuming individual, at least when I saw him. One event stuck in my mind because it so surprised me happened when I had gone over to brief him one-on-one before an interview he was going to have on some health policy issue. I was walking him through the various kinds of questions I thought might get posed in part to stump him and suggested some strategies he might want to follow if that happened. He looked over and smiled and he said, "You think I'm going to screw this up, don't you?" or words to that effect.

He was kind, teasing; a very, very nice person; not a good campaigner but I was able to observe how well he did in small settings of 40, 50, even maybe 100 people. But he could become wooden and uncomfortable in very large settings that mainly involved backslapping and being a politician, which he didn't like.

Berkowitz:

I see. That's interesting.

Wilensky:

It was interesting. I also could observe how engaged he became in meetings involving defense and foreign relations issues because I was allowed to sit in on some of those meetings. While it wasn't that he wasn't interested or didn't understand the importance of

the domestic policy issues, the intellectual depth and passion that existed in these other areas was clear.

Berkowitz:

That's interesting; he had been Ambassador to China and CIA director.

Wilensky:

Yes, exactly. He had a very deep international background.

Berkowitz:

One other question if I might. Henry Kissinger or somebody said that if you go to work in the White House, you're not going to develop any new intellectual capital. You're going to use the intellectual capital that you have. Was that true for you?

Wilensky:

Well, it's basically true. But I found -- because I have found myself in many situations that I wasn't trained to be in over the last say 30 years -- that if you are a good observer, you can learn a lot of things just by watching about managing large organizations and about savvy politicians; so I learned things but not probably those things that would normally be regarded as building intellectual capital but are very important life skills in terms of being more effective in a variety of positions. But there certainly is truth in what Henry Kissinger has said because you are so busy all the time. This was true running HCFA as well. It was absolutely unrelenting. My children were both in college at that point when I had been named by the White House. We had just dropped Sara, our younger child, off at Amherst and so I didn't have the constraints of children at home. I worked seven days a week, long days Monday to Friday, kind of a medium day Saturday, and a shorter day on Sunday on the grounds that this was a limited experience that I would have and I wanted to be as involved as I could. In the White House, you also worked long hours and were on call at any time should something come up and that makes it hard to build intellectual capital.

Berkowitz:

I wanted to ask you about some of the other things you've been doing. You've been doing a lot of different things, but the one thing I wanted to be sure to ask you about was you worked on both the Physician Payment Review Commission and the Medicare Payment Advisory Commission from about 1995 to about 2001 -- chairing both of those at one time or other. Could you just give me a feel for that? Is this work something also of a political exercise or is it an academic exercise, or what?

Wilensky:

It's a bit of both. Thus far I'm the only person who's both run the program, which means being part of the Executive Branch, and has also chaired these advisory commissions which are primarily advisory to the Congress. I think it was very helpful to move to PPRC or MedPAC after having been administrator of the program rather than to do only one or the other. To give just a small example, when MedPAC would be making its recommendations, I insisted that it made clear whether the recommendation was something that could be done administratively or required new legislation. I can remember being quite annoyed when I was testifying and a member of Congress would say PPRC or ProPac -- which was the Part A Advisory Commission that went along with PPRC--or the

Institute of Medicine, or whoever was opining, said the agency should do X and my response is “sounds good to me. I don’t have the legislative authority to do that. You could do that but I can’t do that.” So as somebody who had to live that, I thought it was just very important to be clear whether a commission recommendation was something that could be enacted administratively or required new legislation. So, that’s just sort of a petty example of how having sat in the other seat gives you a fuller view of the issues.

Berkowitz:

And what’s useful.

Wilensky:

Right. And what is important to note because if it is a good recommendation and you’re serious about trying to push this forward, you need to be very clear as to whether or not you are indicating to the Congress, which is the direct recipient of both initially PPRC and then MedPAC reports, that this is something you must do, make happen, and can’t point to HHS and say why aren’t you doing that? I mean, you can, but it’s not very useful.

Berkowitz:

Right. Are there also statutory responsibilities for collecting statistics like the trustees of the trust funds in Social Security do?

Wilensky:

There are legislative directives about what MedPAC must do; these are presented in the March and June reports. In MedPAC’s March report the Commission recommends updates for the various components of Medicare and in the June report, it looks at broader issues of Medicare and health policy. In addition, there are frequently specific requests that the Congress will make of MedPAC that might result in just a letter or a study with a short report, on a particular issue relating to Medicare.

The statute defines the composition in terms of the number of people who will be on the Commission. A majority have to not represent groups that are direct recipients of funds, so not directly self-interested. Then, traditionally there are certain groups that have representation such as representatives of the academic health community or the health insurance industry or the consumers as defined by an AARP-type organization.

But, as I said, what is there in statute is that the majority have to be non-direct recipients of funds. It is not political and, in fact, it was very interesting for me as somebody who had been a presidential appointee, although not regarded as a very political person by either the Democrats or the Republicans, to be the chair of MedPAC. At MedPAC you really are regarded as Congress’ person in these matters; in the way CBO is the offset to OMB, MedPAC is the offset to HCFA/ CMS. It means you are obligated to try to be bipartisan or nonpartisan in as much as you can and to remember when you’re testifying that you are testifying on behalf of the Commission to the Congress and you are Congress’ advisor.

It was very clear to me as somebody who had been a Republican presidential appointee working with a Democratic Congress, how the MedPAC position differed. As a Republican presidential appointee at HCFA, even though I had quite good relations with the Democratic Congress because I had worked with them as a technical advisor before I was

a political appointee, there were nevertheless times when it was useful for them to treat me as a political presidential appointee. But when I was the MedPAC Chair, even some of those same individuals who would, on occasion, find it useful to beat me up in a hearing, would regard me in a completely different manner as MedPAC Chair.

Berkowitz:

As a resource for information?

Wilensky:

Exactly. I think MedPAC and its predecessor commissions have served a very important function for the Congress and continue to do so. Glenn Hackbarth has just stepped down as a longtime Chair after I was. I told him he has now joined a very exclusive club that used to only have a member of one, me, and now there will be two, which is former MedPAC Chairs.

Berkowitz

To get on MedPAC, do you have to be named by a congressman? How does that work?

Wilensky:

The actual appointment initially was made by the Office of Technology Assessment and then when OTA went away it became the Comptroller General at GAO. So around 1995 or so, the formal appointment moved to GAO. How active members of Congress are influencing some of the appointments depends on how interested they are. Various congresses have been more or less interested, particularly those on the relevant committees, usually Ways and Means, and Finance. If members of Congress that are active in healthcare, and particularly if they're part of the majority party, wish to influence some appointments, as long as they are within a credible group of candidates, most GAO comptroller generals will pay attention. Having various groups that are supposed to be represented strongly support a candidate is important. How that all plays out just depends, over time, on how proactive the comptroller general wants to be versus how responsive to these other groups the comptroller general wants to be and that has differed over time.

Berkowitz:

So, let me skip to the second Bush administration, the younger -- 43. Was there much continuity in personnel?

Wilensky:

I had been involved somewhat formally and a lot informally with the campaign. I was there to be an advisor. I have been involved informally and sometimes formally in all of the Republican campaigns other than the first and second Romney campaigns. I was involved with, through McCain, a little bit advising in 2012 -- but not in any formal way and really minimally, much less than I had been previously.

Berkowitz:

I'm curious about how involved you might have been in making suggestions about staffing the new administration in terms of, for example, who would make a good person for X, Y or Z position.

Wilensky:

I had some of those discussions. I had more contact with senior people in the White House than with the President. I had traveled a couple of times with the President during the campaign and more it was when personnel were being considered, senior people might call me to ask what I thought. During the two terms that 43 was in office, on a number of occasions I was invited to small meetings in the White House about health policy issues.

Berkowitz:

I know a lot of Robert Kennedy's advisors were also John F. Kennedy's advisors because the family used them. Was there something similar going on with the Bush family or were they such different people that that didn't happen?

Wilensky:

Well, there were some people who were active in both. It's hard to know exactly why it happens when it does. Condoleezza Rice was somebody who became a family friend and was very close to 41 and also became close to 43. There were a few people like that. My involvement in the second Bush administration was probably more because I had been helpful in the campaign and knew healthcare; I had some indirect involvement for 43.

Just as I was stepping off MedPAC at the end of the six years of those two commissions, I got a call from somebody who had been a senior person in the campaign and remained senior in the White House and asked would I consider co-chairing a presidential taskforce on VA/DOD healthcare. It was literally like two weeks before I was stepping down from MedPAC. I said I know something about VA and DOD healthcare because I've had involvement while at HCFA, but I am not an expert in either of those. They said we have plenty of people who are experts in those; we need somebody who's an expert in health policy. I said sure, I'd be glad to do that. It started a number of appointments over the course of the next eight years, two that continue now, in which I've been involved with VA and DOD healthcare issues.

Berkowitz:

This is a new bureaucracy for you, right?

Wilensky:

Newer. I had some contact but nothing like the kind of contact I began to have with this presidential taskforce followed by being asked to co-chair a congressionally mandated taskforce on the future of military healthcare, which I did along with then vice chief of staff of the Air Force, a four-star general: John Corley, one of the seven people on the Dole-Shalala Presidential Commission on the care of our returning wounded warriors after the Walter Reed fiasco.

Berkowitz:

Robert Dole --

Wilensky:

Yes, but the person who pressed to have me appointed to this commission was actually Donna Shalala.

Berkowitz:

Really?

Wilensky:

Yes, that's the normal response I get.

When she was Secretary of HHS, after the Republicans took over the House in the 1994 election, she asked me to come in periodically every couple of months and translate for her what these Republicans were trying to do in Congress. She knew me as someone who was well regarded as a health policy person, and we got to know each other as professional colleagues during that period. When she was named to co-chair to this presidential commission with Bob Dole, she had called to ask if I were asked would I do this. Even though I was already devoting a huge amount of my time to this other congressionally mandated taskforce that I was co-chairing, I said yes, of course I would do that. And she was the one who insisted that I be a member because I actually knew something about how these programs operated both the VA and the DOD. Most of the seven people on the commission, including Donna Shalala, didn't really understand the workings of these two large bureaucracies.

Berkowitz:

Didn't your husband work as a military doctor?

Wilensky:

He was in the Army for two years. He was a general medical officer in Vietnam for a year which was of great assistance to me during this first presidential taskforce because some of the more aggressive members of Congress who were from different special interests than I had represented grudgingly had to acknowledge I had some ties because my husband had served in Vietnam. But they are very different kinds of bureaucracies.

I was very impressed with how strong the bond between Bob Dole and the military is; that is, with the existing military, many of whom are way, way, way younger than he is. It was clear he loved them and they loved him and when we would go visit some of the military facilities, it was just absolutely clear that bond was very strong.

Berkowitz:

When President Franklin Roosevelt was trying to figure out about healthcare for World War II and aftercare for veterans of World War II, he tried for a while to have a merger of civilian and veteran rehabilitation which didn't get very far, which is often the case in those things. Do you have a different take on that now?

Wilensky:

I think we are going to get to think about that once again, not necessarily for the rehab part. I think over the course of say the next decade we're going to have to rethink the role of the VA in a country that has largely reduced the number of uninsured. I say that because if you look around at the world, except for Australia which maintains a separate veteran's health program, all of the other developed countries that have national health systems or health insurance of some sort that cover the vast majority of their population do

not have separate VA systems. I think we are going to have to think hard about what function we want for the VA, which never has treated the majority of veterans.

Right now there are something like 23 to 25 million veterans; 7 or 8 million are enrolled in the VA and active users are 6 to 7 million. We will need to consider if we want to think of the VA as an increasingly specialized place of care for multiple serious wounds of war, for limb replacement, amputation, for spinal cord injury and stroke, and for mental health, broadly defined, as opposed to a place of general healthcare for people who have had an active involvement in the military and could be eligible under current rules.

Berkowitz:

Right. I hadn't thought about that. The elements of the VA system go back to a time when a significant number of people didn't have access to healthcare and this was like a perk for the veterans, often living in areas that are quite remote.

Wilensky:

Remote, right. Now, given the difficulties we have been experiencing as of late with a VA that is struggling to provide care to numbers of individuals in an appropriate time-sensitive way, I think we need to really think about these things. Do we want to just pour more money on to try to make the current system capable of providing needed care timely? Do we want to think over time about which populations might transition out to non-VA care and which populations could better be treated within the VA because of their specialized needs, or the fact that the non-military healthcare system doesn't really know how to treat certain kinds of wounds and injuries particularly well and they have developed in the VA this expertise?

It will be politically a challenge because redefining what have been roles over the past several decades never happens easily. But I think we will at some point get pushed on this issue of what we think makes sense going forward and then how do we make sure we provide care for the existing population as it wants to use it.

One of the frustrations is that like the dual-eligibles between Medicare and Medicaid, those people who have multiple eligibilities in the civilian and military systems frequently get the most expensive disjointed care imaginable because the various systems don't know what else that person is using. People go to the VA, they go into a DOD system, and they're on Medicare. None of these groups exchange medical records or understand who else is treating that person, sometimes deliberately because the individual is purposefully not sharing that information, sometimes because the systems don't allow that sharing.

Berkowitz:

So we were talking about veterans and even I know that the politics are hard. Once doing research I went to talk with somebody in the Veterans Administration. I said "tell me about these welfare programs you run," and he looked at me and said "we don't have any welfare programs." And then later in the meeting I made the same mistake again and he said, "I told you before we don't have any welfare programs and if you make any mention of that in your report, I'll have somebody in Congress stand up and denounce you." I had never quite seen so naked a display but there's clearly a very possessive attitude about these programs.

Wilensky:

Yes and some organizations are very aggressive in their use of Congress. They frighten or bully many members of Congress even though it's not always clear how strong the actual political clout of some of these organizations are, but they act as though it is and most members aren't willing to try and find out just how strong their support is.

The notion is that the military benefit is an earned benefit, not welfare and you shouldn't use the term, that's not an appropriate term. But it is a very odd earned benefit in terms of healthcare because it isn't available to anyone just because they're a veteran. They have priority categories only within that. Do you stand any real opportunity to access the benefit? That's why it has traditionally been used either by people who had no other insurance or who had particular kind of injuries that the VA was well-suited to treat, some of which had nothing to do with the war. It may be someone who had served who wrapped their motorcycle around a tree, rather than obtaining injuries in war.

Berkowitz:

Right. It also seems to me that it's related to the politics of hospital closings and all that. For example, New Haven has a big veterans' hospital and many other places have, and a change in systems would have implications for these hospitals.

Wilensky:

What happens to those now? Unfortunately many of the veterans' facilities are not in the areas where the veterans go anymore. There's been a large movement of veterans to warmer climates, and many of the facilities are not there and the question is going to be do you invest in money to open facilities where the veterans are? Do you try to have joint activities? The veterans' representative groups have fought sharing of facilities either with the DOD or with the private sector, and this is going to become an issue periodically. I've said it's why, I believe, at some point that Congress is going to have to take on this longer-term issue: what is the role they see for the VA ten years out and going forward.

Berkowitz:

It's very interesting. Moving onto a new line of inquiry, I wanted to ask you about your involvement with the United Mine Workers.

Wilensky:

I'll tell you how it happened but what is interesting is that 22 years later I'm still doing it. I enjoy it. They like having me.

When I was in the White House, one of the pieces of legislation I helped coordinate was the Energy Act which had a Coal Act as part of it. I helped oversee things to make sure there were no components that the White House would find strongly objectionable at the policy level. The Coal Act was intended to try to infuse additional money into the promise that had been made to treat the miners differently; in particular, it related to the agreement that the unionized companies had made -- the evergreen clause that these promises of healthcare benefits would continue forever for the miners and anybody related in a quite generous definition of relationship.

When this was going on, I was shepherding the bill in the sense of looking at the policy. There were other people who were much more legislatively involved who were in the legislative shop of the White House. But while doing that, I helped signal some changes that I thought smacked of an employer mandate. There was some consideration of applying mandates to nonunionized companies that had never made this promise as though they were equally responsible for funding the promise made by the unionized companies; I felt this was singularly inappropriate to do, that they were no more responsible for funding these promises of the unionized companies than the rest of the employer sector of the country.

So, I was involved in that kind of a sense. What I didn't remember and I don't think I ever actually had any reason to realize this, is there had been a provision to set up a seven-person trusteeship to oversee the combined benefit fund. That was what I was appointed to. It has two trustees from the unions, two from the management, and three neutrals -- one representing the union side and one representing, or leaning toward, management side, and a neutral, neutral.

Berkowitz:

Are you neutral, neutral?

Wilensky:

I am the management-oriented neutral, but both the unions and the BCOA companies, Bituminous Coal Owners Association, have to agree on the neutrals and I had a good relationship with the UMWA when I was running Medicare. There had been a dispute when I came in that almost derailed my confirmation, or at least almost postponed it. I had promised I would actively look into it and resolve it if I was confirmed, which I did. Combined with that was this experience I had with the Coal Act. So when it came time for them to find somebody who would be the management-oriented neutral, I got a call saying would I be interested.

I had no idea that this was a part of something I had been involved with at a very different level but it sounded like it was interesting. It has been very interesting and I'm really, of the seven trustees, the only person who comes out of a health background. It is an interesting mix of trustees with different skills and backgrounds, but having somebody who is knowledgeable about what's going on in Medicare, what's going on in healthcare in general, has been very helpful.

I find it very interesting to see what a union group can do, especially if it is one that is promised all imaginable benefits because it now becomes in its interest to take a much broader view than might otherwise be the case. So, for example, if they are seeing someone who has repeated falls, they will send somebody into the home to see whether there's something that could be done to stop that from happening because they're going to be responsible, assuming it's not too complicated.

Another example is when there was an extraordinary blip-up in the use of ambulances for people who were in certain parts of very remote areas it was clear they were having a transportation problem, and it was agreed by the trustees that it would be better to find a way to have alternative transportation and not have them use an ambulance because they

didn't need an ambulance. The patients needed to be able to get to their healthcare site and this was not a smart way to do it.

It has also made clear that when the union tells these retirees and dependants that it needs to make certain changes in order to make sure that the benefits can continue given the funding it has, there is such a large amount of trust that the changes can be implemented. These are the kind of changes that if Medicare tried, they'd tear your heart out. But when the union tells its membership this is what we need to do to make sure that you can continue getting your benefits, it is almost always adopted.

Berkowitz:

Wow, interesting.

Wilensky:

Very. There are many activities that this group is doing that -- for a group that is financially responsible for all health care, broadly defined, -- make sense. It would make less sense for someone who is a narrower payer.

I'm frequently asked does it make sense to make a particular change because it would save costs. I almost always reply asking "Whose costs would be saved?" This is not a matter of indifference. If it saves Medicaid's costs but I'm a Medicare head, it's not so relevant to me. If it saves the Medigap plans money or even saves individuals out-of-pocket expenses but is not a Medicare cost, that's a hard sell to a head of Medicare because that's going to be an added Medicare cost. You're going to have to come up with offsetting expenditures somewhere else in the budget. So, this issue of whose costs are affected is very important in general. For this group, it's rarely very relevant and so you have some very interesting innovative programs that you can try.

Berkowitz:

Yes, it's very interesting and something I hadn't thought about at all.

I wanted to ask you about the Affordable Care Act and a little bit about CMS, if we have time. First, I am curious to know if you were surprised that they actually managed to get a bill, get the Affordable Care Act?

Wilensky:

Well -- yes. Once Senator Kennedy died, it looked very tenuous. Had they not engaged in some creative maneuvers on the Hill, it would not have become a law.

I support the notion of having coverage expanded. We need to substantially reduce the number of people without insurance. There are a lot of things I don't like about the Affordable Care Act that I would like to see modified, but I would only like to see it modified as long as coverage continues as great as or greater than it is under the Affordable Care Act. We have got to figure out how to do that.

It is, I think, very unfortunate how it was passed for two reasons. The enmity, the partisan response continues to haunt to this day. Enormous ill will was created between the parties, largely because we don't behave very well when one party is sufficiently dominant

to the other that it doesn't need bipartisan support. It does not tend to result in good behavior. And second, the way it was passed meant that some of the normal reviews that go on during conference process did not occur resulting, for example, in the controversy involved in the Supreme Court case *King v. Burwell*.

It's not that those kind of things never previously happened where you had complex legislation where one piece was inconsistent with other parts of legislation. I had something like that happen with the new physician payment system -- the resource based relative value system, RBRVS -- that I was responsible for implementing. But usually if it was clear what was intended, the Congress would do a rifle shot to clarify what should have been there, which wasn't.

Some of the areas in the ACA -- like this infamous IPAB, Independent Payment Advisory Board, which gives enormous power to this group and the Secretary -- would not have survived, in my opinion, a reconciliation process because many members of Congress, Democrats as well as Republicans, were very wary of the change in power from the legislative branch to the executive branch that was occurring with this component in the legislation. I believe that would have been knocked out.

Berkowitz:

But it might ultimately not go into effect, right?

Wilensky:

Well, at the moment, nobody has been appointed because nobody would ever get confirmed. It hasn't been needed because healthcare spending is so low. It is number one on my target list of "blow it up while it's cheap," which it is now because spending has been low. It is one of these cases where the cure is even worse than the disease. A Congress that is not as active as it should be and deciding how to limit spending, making it subject to a group of individuals who once appointed are totally unaccountable, is even worse to me.

Berkowitz:

I see. So, just to put a cap on this, if you were Jeb Bush or you were advising somebody who was a prominent Republican, what would you tell them? This is a little bit like advising the Republicans in 1972 about Medicare.

Wilensky:

Well, I'm writing a short piece right now for JAMA about refinements and improvements of the Affordable Care Act that I would like to see occur. My recommendations would be to be sure to remember that the changes will need to produce coverage of at least the same numbers that we're talking about. And then I'd recommend taking on some near-term and some medium-term issues in terms of what to change. Getting rid of IPAB would be a near-term issue.

Another thing to change would be the mandate. The revised plan could use the Medicare strategy of strongly encouraging, incentivizing people to purchase insurance rather than having a mandate, per se.

Medicare doesn't require people to buy the physician Part B; there are strong incentives, however, to do so when a person becomes eligible. Similarly, the outpatient prescription drug law says if you don't sign up once you turn 65 -- unless you have other group insurance that provides credible coverage, which means comparable coverage -- you will face a penalty for every month you delayed after that initial period. It has produced very high rates of compliance on a voluntary basis.

Berkowitz:

Right, and of course, when they created that in 1965, the Social Security Administration spent a lot of time getting people to sign up for that and there was no question that they thought everybody should do so.

Wilensky:

People want coverage. And I think it was extremely unfortunate that we didn't even try this strategy with ACA, the same strategy of saying you have the first year open once it's available on a subsidized, non-discriminatory basis. If you don't choose to buy insurance, at whatever point you choose to buy insurance, and at some point most people are going to want insurance, there will be a penalty assessed for the time that you waited because of the cost you impose on other people with adverse selection. Not because you're being mean, but because you want to recover those costs and that's how you're going to do it.

Now it could have been -- it was possible that two or three or three or four years out, the conclusion would have been too many people aren't signing up and it is causing an unstable insurance system and you could have gone to another step. But I am very angry they didn't even try this strategy and instead convulsed the country with this mandate angst, which I think is one of the factors responsible for the fact that five years later, only half of the people, at best, say they approve of it.

Berkowitz:

I have one last round of questions, if I might, going back to HCFA. There are a lot of questions about the agency, one of which is that both the Democrats and the Republicans, when they've had the presidency, have had trouble getting nominees for the administrator approved. So there have been a lot of acting administrators as a result, and I was curious about that. Does having an acting administrator affect the agency's performance?

Wilensky:

Yes.

Berkowitz:

You agree with that strongly?

Wilensky:

Yes, I believe that. Now, traditionally getting the CMS administrator through has not been nearly as challenging as getting the FDA Commissioner through, particularly in Democratic administrations, if the FDA Commissioner has any tie with industry broadly defined in any way. So if you have a Republican in the White House and you have a Democratic Congress, the people they might be inclined to turn to may have different backgrounds and

that has been much more contentious traditionally than getting the HCFA/CMS administrator through.

Obviously there have been two times where there was a lot of contention. One was with Kerry Weems when Mark McClellan stepped down in the fall of 2006. That was because some of the Democrats in Congress were angry about some Medicaid regulations that CMS had produced and they were using that as a payback. So, in this case actually, it had nothing to do with Kerry Weems himself who had been a civil servant before going to work for Mike Levitt at EPA. It's not surprising that it actually wasn't personal toward Kerry Weems but it was payback for something the agency had done.

The second time, obviously, it was Don Berwick. Had the administration nominated Don Berwick in the spring of 2009 when they were already speaking to him as they did Peggy Hamburg for FDA, I think there would have been no question raised about his past. It was that the administration chose not to nominate a CMS administrator despite the fact that the agency had been without a confirmed head since 2006 until after the ACA was passed. After that it was hard to imagine anybody, almost, getting through because the Republicans were on a tear about the legislation that had just been signed into law. Don Berwick made it exceedingly easy to be the target because of various, shall we say, impolitic comments that he had made during his academic life.

Berkowitz:

And in academics, of course, people are prone to make such comments.

Wilensky:

Exactly, yes. I recently wrote a column piece that was in Milbank about some of the issues raised around remarks by Jonathan Gruber. First, there is no such thing as off the record. People who haven't gone through this process and are advising presidents or administrations or other elected officials need to learn that. But some of the issues Gruber raises about obfuscation -- is it okay to deliberately hide parts of legislation because that's what you think it takes to get them through, even if the legislation is good -- are worthy of serious consideration.

Berkowitz:

Yes, of course, of course. I have one last question.

If someone calls you on the phone saying we're going to have a new presidential administration and what should I be looking for in a CMS administrator; what would you respond?

Wilensky:

The job, I'd say, requires somebody who understands the issues, who's not tone deaf about the politics; it is helpful if they've had some experience working with the Congress; it helps if the person knows what they know, knows what they do best, and knows what they don't do as well when it comes to running a big organization. You don't necessarily have to have had operations experience, although it would be good if you did, like Marilyn Tavenner; it is helpful to have had political experience like she had having been Secretary of Health in a purple state, which was especially good background and practice.

It helps if you understand these issues are very important and will seek to support yourself in any areas where you're deficient. No one is going to be equally strong in all areas. The real problem is many people don't understand why many of the issues dealt with by CMS are so important. That's when you get in trouble.

Berkowitz:

That's a great note on which to end. Thank you.